CHAPTER 1: RESIDENT ASSESSMENT INSTRUMENT

1.1 Overview of the Resident Assessment Instrument (RAI)

Providing care to residents with post-acute and long-term care needs is complex and challenging work. It utilizes clinical competence, observational skills, and assessment expertise from all disciplines to develop individualized care plans. The Resident Assessment Instrument (RAI) helps facility staff to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. It also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practicable level of well-being.

The RAI helps facility staff to look at residents holistically - as individuals for whom quality of life and quality of care are mutually significant and necessary. Interdisciplinary use of the RAI promotes this very emphasis on quality of care and quality of life. Facilities have found that involving disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy and activities in the RAI process has fostered a more holistic approach to resident care and strengthened team communication.

Persons generally enter a nursing facility due to functional status problems caused by physical deterioration, cognitive decline, the onset or exacerbation of an acute illness or condition, or other related factors. The individual's ability to manage independently has been limited to the extent that skilled nursing, medical treatment and/or rehabilitation is needed for residents to maintain and/or restore function or to live safely from day to day. While we recognize that there are often unavoidable declines, particularly in the last stages of life, all necessary resources and disciplines must be used to ensure that residents achieve the highest level of functioning possible (Quality of Care) and maintain their sense of individuality (Quality of Life). This is true for long-term residents, as well as the resident in a rehabilitative program anticipating return to a less restrictive environment.

Clinicians are generally taught a problem identification process as part of their professional education. For example, the nursing profession's problem identification model is called the nursing process, which consists of assessment, planning, implementation and evaluation. The RAI simply provides a structured, standardized approach for applying a problem identification process in long-term care facilities. The RAI should not be, nor was it ever meant to be, an additional burden for nursing facility staff.

All good problem identification models have similar steps:

a. Assessment - Taking stock of all observations, information and knowledge about a resident; understanding the resident's limitations and strengths; finding out who the resident is.

- **b. Decision-making** Determining the severity, functional impact, and scope of a resident's problems; understanding the causes and relationships between a resident's problems; discovering the "what's" and "whys" of resident problems.
- **c. Care Planning** Establishing a course of action that moves a resident toward a specific goal utilizing individual resident strengths and interdisciplinary expertise; crafting the "how" of resident care.
- **d. Implementation** Putting that course of action (specific interventions on the care plan) into motion by staff knowledgeable about the resident care goals and approaches; carrying out the "how" and "when" of resident care.
- **e. Evaluation** Critically reviewing care plan goals, interventions and implementation in terms of achieved resident outcomes and assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in the resident's status, either improvement or decline.

This is how the problem identification process would look as a pathway. This manual will feature this pathway throughout the chapter discussions.

Assessment	Decision-Making	Care Plan	Care Plan	Evaluation
(MDS/other)	(RAPs/other)	Development	Implementation	n

If you look at the RAI process as solution oriented and dynamic, it becomes a richly practical means of helping facility staff to gather and analyze information in order to improve a resident's quality of care and quality of life. In an already overburdened structure, the RAI offers a clear path toward utilizing all members of the interdisciplinary team in a proactive process. There is absolutely no reason to insert the RAI process as an added task or view it as another "layer" of labor.

The key to understanding the RAI process, and successfully using it, is believing that its structure is designed to enhance resident care and promote the quality of a resident's life. This occurs not only because it follows an interdisciplinary problem-solving model, but also because staff, across all shifts, are involved in its "hands on" approach. The result is a process that flows smoothly from one component to the next and allows for good communication and uncomplicated tracking of resident care. In short, it works!

Since the RAI has been implemented, facilities that have applied the RAI process in the manner we have discussed have discovered that it works in the following ways:

Residents Respond to Individualized Care. While we will discuss other positive responses to the RAI below, there is none more persuasive or powerful than good resident outcomes both in terms of a resident's quality of care and quality of life. Facility after facility has found that when the care plan reflects careful consideration of individual problems and causes, linked with appropriate resident specific approaches to care, residents have experienced goal achievement and either the level of functioning has improved or deteriorated at a slower rate. Facilities report that as individualized attention increases, resident satisfaction with quality of life is also increased.

Staff Communication Has Become More Effective. When staff members are involved in a resident's ongoing assessment and have input into the determination and development of a resident's care plan, the commitment to and the understanding of that care plan is enhanced. All levels of staff, including nursing assistants, have a stake in the process. Knowledge gained from careful examination of possible causes and solutions of resident problems (i.e., from using the Resident Assessment Protocols (RAPs)) challenges staff to hone the professional skills of their discipline as well as focus on the individuality of the resident and holistically consider how that individuality must be accommodated in the care plan.

Resident and Family Involvement in Care Has Increased. There has been a dramatic increase in the frequency and nature of resident and family involvement in the care planning process. Input has been provided on individual resident strengths, problems, and preferences. Staff members have a much better picture of the resident, and residents and families have a better understanding of the goals and processes of care.

Increased Clarity of Documentation. When the approaches to achieving a specific goal are understood and distinct, the need for voluminous documentation diminishes. Likewise, when staff members are communicating effectively among themselves with respect to resident care, repetitive documentation is not necessary and contradictory notes do not occur. In addition, new staff, consultants, or others who review records have found that the increased clarity of the information documented about a resident makes tracking care and outcomes easier to accomplish.

It is the intent of this manual to offer clear guidance, through instruction and example, for the effective use of the RAI, and thereby help facilities achieve the benefits listed above.

In keeping with objectives set forth in the Institute of Medicine (IOM) study completed in 1986 that made recommendations to improve the quality of care in nursing facilities, the RAI provides each resident with a standardized, comprehensive and reproducible assessment. It evaluates a resident's ability to perform daily life functions and identifies significant impairments in a resident's functional capacity. In essence, with an accurate RAI completed periodically, caregivers have a genuine and consistently recorded "look" at the resident and can attend to that resident's needs with realistic goals in hand.

With the consistent application of item definitions, the RAI ensures standardized communication both within the facility and between facilities (e.g., other long-term care facilities or hospitals). Basically, when everyone is speaking the same language, the opportunity for misunderstanding or error is diminished considerably.

1.2 Content of the RAI for Nursing Facilities

The RAI consists of three basic components:

1. Minimum Data Set (MDS) Version 2.0,

- 2. Resident Assessment Protocols (RAPs), and
- 3. **Utilization Guidelines** specified in State Operations Manual (SOM) Transmittal #272.

Utilization of the three components of the RAI yields information about a resident's functional status, strengths, weaknesses and preferences, and offers guidance on further assessment once problems have been identified. Each component flows naturally into the next as follows:

- Minimum Data Set (MDS). A core set of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies. A copy of the MDS Version 2.0 can be found at the end of this chapter.
- Resident Assessment Protocols (RAPs). The RAPs are structured, problem-oriented frameworks for organizing MDS information, and examining additional clinically relevant information about an individual. RAPs help identify social, medical and psychological problems and form the basis for individualized care planning. The 18 RAPs are explained in detail in Appendix C. There are four components in the RAPs protocols:
 - *Triggers* are specific resident responses for one or a combination of MDS elements. The triggers identify residents who have or are at risk for developing specific functional problems and require further evaluation.
 - The *Trigger Legend* is a two-page form that summarizes all of the triggers for the 18 RAPs. It is not a required form that must be maintained in the resident's clinical record. Rather, it is a worksheet that may be used by the interdisciplinary team members to determine which RAPs are triggered from a completed MDS assessment.
 - The *RAPs* analysis is performed in accordance with the Utilization Guidelines. The indepth review assists the staff members to draw a conclusion to proceed or not to proceed to the plan of care.
 - The *RAPs Summary Sheet* documents the decisions made during this evaluation process on whether or not to proceed to care planning.
- **Utilization Guidelines**. Instructions concerning when and how to use the RAI. Application of the RAPs and the Utilization Guidelines is discussed in detail in Chapter 4.

1.3 Additional Uses of the Minimum Data Set

Over the course of time, the role of the MDS has expanded beyond its primary purpose as an assessment tool used to identify resident care problems that are addressed in an individualized care plan. Data collected from MDS assessments is used for the Medicare reimbursement system, many

State Medicaid reimbursement systems, and to monitor the quality of care provided to nursing facility residents. The MDS instrument has also been adapted for the hospital swing bed program. Swing bed providers are required to complete a unique 2-page MDS for the Medicare Prospective Payment System (PPS).

Medicare and Medicaid Payment Systems

The MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. The MDS is used as a data collection tool to classify Medicare and Medicaid residents into the Resource Utilization Groups (RUG-III). The RUG-III Classification system is used in the PPS for nursing facilities, hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the purposes of reimbursement. Chapters 2 and 6 provide more detailed information on the Medicare Prospective Payment System, assessment requirements, and payment requirements.

Monitoring the Quality of Care

MDS assessment data is also used to monitor the quality of care in the nation's nursing facilities. A set of 24 quality indicators (QIs) was developed by researchers to assist State staff to identify potential care problems in a nursing facility. CMS is currently evaluating the usefulness of these indicators and is considering additions and modifications to further enhance the effectiveness of the QI system. The QI data is available to providers to assist them in their ongoing quality improvement activities, to surveyors to assist in identifying potential problem areas that should be addressed during the survey process, and to CMS for long-term quality monitoring and program planning.

Consumers are also able to access information about every Medicare and Medicaid certified nursing facility in the country. The Nursing Home Compare tool available at **www.medicare.gov** provides the following sections of detailed information:

- About the Nursing Facility: Including the number of beds and type of ownership.
- **About the Nursing Facility Inspection:** Including health deficiencies found during the most recent State nursing facility survey and from recent substantiated complaint investigations.
- **About Nursing Facility Staff:** Including the average number of hours worked by registered nurses, licensed practical nurses, and certified nursing assistants per resident per day.
- About the Quality of Care Received at the Facility: In 2002, CMS began a new program called the Nursing Home Quality Initiative (NHQI). The purpose of this program is to provide consumers with information on the quality of care delivered in nursing facilities to help them make informed decisions. CMS expanded the original quality indicators to a set of 39 quality measures. These quality measure domains include pain and measures for the short-stay and post-acute population. A subset of 10 quality measures are posted on the Nursing Home Compare web site, a CMS developed internet search tool to allow comparisons between nursing facilities. The public reporting initiative was successfully piloted in six states, and, beginning in November 2002, was expanded to all fifty states as well as to U.S. territories that have Medicare or Medicaid certified nursing facilities.

The Nursing Home Compare web site is:

http://www.medicare.gov/nhcompare/home.asp.

1.4 Suggestions for the Use of this Manual

This manual is designed to meet the needs of nursing facility staff who are both skilled in the use of the RAI process and staff who are just beginning to work with it.

This revised manual includes information about:

- MDS automation
- Reimbursement
- Quality monitoring applications

It also includes new case studies and expanded clarifications for the original item-by-item section information of the October 1995 Version 2.0 Long-Term Care Resident Assessment Instrument User's Manual and "how-to" directions for completing the RAP review process and documentation requirements.

The following fundamental concepts associated with the RAI are interwoven as themes throughout this manual:

- The resident is an individual with strengths, as well as functional limitations and health problems.
- The RAPs are utilized to identify possible causes for each problem area, and guidance for further assessment and resolution or intervention
- An <u>interdisciplinary</u> approach to resident care is vital both in assessment and in developing the resident's care plan.
- Good clinical practice requires solid, sound assessment.

In essence, this manual promotes a step-by-step system of assessing resident needs and functional status based on standardized definitions of items (the MDS). It then helps you think through possible reasons for and risk factors that contribute to a resident's clinical status (RAPs). This informative material offers the interdisciplinary team realistic approaches to resident care that is based on specific, individual characteristics.

1.5 Clarifications and Revisions to the Manual

Since the publication of the MDS 2.0 manual in October 1995, a number of additional systems and monitoring protocols that use MDS data have been developed and implemented, such as SNF PPS, nursing facility quality of care monitoring, and the public reporting of nursing facility quality of care information.

In addition, CMS established a process for answering questions and clarifying MDS coding instructions for nursing facility staff. CMS posted responses to questions on their web site. These responses are now incorporated into this manual. The instructions in this revised manual incorporate and supercede previous Q&A documents.

CMS recognizes that the publication of this revised manual will not preclude future questions or the need for more clarification about MDS items. Therefore, CMS has developed a procedure to review, respond and distribute clarifications to the MDS coding process.

- STEP 1: If clinicians have a question about a particular MDS item, they should first review the manual and then contact their State RAI Coordinator for a clarification. If necessary, the State RAI Coordinator will contact the appropriate CMS staff if he/she is not able to answer a specific question.
- STEP 2: CMS will determine if a clarification about an item is needed and will post new clarifications on the CMS web site. If a clarification is posted on the official CMS web site, then it can be considered policy. CMS will develop a process to periodically update the manual and incorporate additional clarifications. Clinicians should monitor the CMS web site at: http://www.cms.hhs.gov/medicaid/mds20 for these clarifications

1.6 Statutory and Regulatory Basis for the RAI in Nursing Facilities

Minimum Data Set (MDS): The statutory authority for the MDS Version 2.0 and the Resident Assessment Instrument (RAI) is found in Section 1819(f)(6)(A-B) for Medicare and 1919 (f)(6)(A-B) for Medicaid in the Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). These sections of the Social Security Act required the Secretary of the Department of Health and Human Services (the Secretary) to specify a minimum data set of core elements for use in conducting comprehensive assessments. It furthermore required the Secretary to designate one or more resident assessment instruments based on the minimum data set. The Secretary designated Version 2.0 of the RAI in the State Operations Manual Transmittal #272, issued April 1995. Revision #22, issued December 8, 2000, required nursing facilities to implement the September 2000 update of the Resident Assessment Instrument (RAI).

Federal requirements at 42 CFR 483.20(b)(1)(i) -- (F272) require that facilities use an RAI that has been specified by the State. This assessment system provides a comprehensive, accurate, standardized, reproducible assessment of each long-term care facility resident's functional capabilities and helps staff to identify health problems. The Federal requirement also mandates facilities to encode and electronically transmit the MDS data from the facility to the State MDS database. (Detailed submission requirements are located in Chapter 5.)

1.7 State Designation of the RAI for Nursing Facilities

All comprehensive RAIs authorized by states include at least the Centers for Medicare & Medicaid Services' (CMS's):

- MDS Version 2.0 (with or without optional Sections S, T, U)
- Resident Assessment Protocols (RAPs), including
 - Triggers
 - Trigger Legend
 - RAPs Summary Sheet
- Utilization Guidelines

Each state must have CMS approval for the State RAI. CMS's approval of a state's RAI covers the core items included on the instrument, the working and sequence of those items, and all definitions and instructions for the RAI. CMS's approval of the RAI does not include characteristics related to formatting (e.g., print type, color coding, or changes such as printing triggers on the assessment form). States must use all Federally required MDS items (see Section 1.9) but have some flexibility in adding one or more optional sections (Sections S, T and U) and in selecting a Quarterly assessment instrument

In addition to approving the State's RAI, CMS must also pre-approve the Quarterly assessment designated by each state. Effective July 1, 2002, CMS approved the Medicare Prospective Payment Assessment Form (MPAF) for use as a Quarterly assessment. States choosing to use the MPAF form as the State Quarterly assessment do not need prior CMS approval. The state is only required to notify CMS that the MPAF has been designated as the State Quarterly assessment.

If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer generated printout of the RAI as long as the state can ensure that the facility's RAI form in the resident's record accurately and completely represents the State's RAI as approved by CMS in accordance with 42 CFR 483.20 (b). This applies to either preprinted forms or computer generated printouts. Facilities may insert additional items within automated assessment programs but must be able to "extract" and print the MDS in a manner that replicates the State's RAI (i.e., using the exact wording and sequencing of items as is found on the State RAI). Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions).

Additional information about State specification of the RAI, variations in format and CMS approval of alternative State instruments can be found in Sections 4145.1 - 4145.7 of the CMS State Operations Manual, Transmittal #272 issued April 1995. Revision #22 issued December 8, 2000 updated RAI requirements and mandated nursing facilities to implement the Version 2.0 September 2000 update of the RAI.

1.8 Protecting the Privacy of MDS Data

MDS assessment data is personal information about nursing facility residents that facilities are required to collect and keep confidential in accordance with federal law. The CFR Part 483.20 requires Medicare and Medicaid certified nursing facility providers to collect the resident assessment data that comprises the MDS. This data is considered part of the resident's medical record and is protected from improper disclosure by Medicare and Medicaid certified facilities under the Conditions of Participation (COP). By regulation at CFR 483.75(L)(2)(3) and 483.75(L)(2)(4)(i)(ii)(iii), release of information from the resident's clinical record is permissible only when required by:

- 1. transfer to another health care institution,
- 2. law (both State and Federal), and/or
- 3. the resident.

Otherwise, providers cannot release MDS data in individual level format or in the aggregate. Nursing facility providers are also required under CFR 483.20 to transmit MDS data to a Federal data repository. Any personal data maintained and retrieved by the Federal government is subject to the requirements of the Privacy Act of 1974. The Privacy Act specifically protects the confidentiality of personal identifiable information and safeguards against its misuse. The Privacy Act can be found at www.usbr.gov/laws/privacy.html.

The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice. Therefore, residents in nursing facilities must be informed that the MDS data is being collected and submitted to the State MDS database. The notice shown on Page 1-11 of this section meets the requirements of the Privacy Act of 1974 for nursing facilities. The form is a notice and not a consent to release or use MDS data for health care information. Each resident or family member must be given the notice containing submission information at the time of admission. It is important to remember that resident consent is not required to complete and submit MDS assessments that are required under OBRA or for Medicare payment purposes.

Contractual Agreements

Providers, who are part of a chain, may release data to their corporate office or parent company but not to other providers within their chain organization. The parent company is required to "act" in the same manner as the facility and is permitted to use data only to the extent the facility is permitted to do so (as described in the CFR at 483.10(e)(3)).

In the case where a facility submits MDS data to CMS through a contractor or through its corporate office, the contractor or corporate office has the same rights and restrictions as the facility does under the Federal and State regulations with respect to maintaining resident data, keeping such data confidential, and making disclosures of such data. This means that a contractor may maintain a database, but must abide by the same rules and regulations as the facility. Moreover, the fact that there may have been a change of ownership of a facility that has been transferring data through a contractor should not alter the contractor's rights and responsibilities; presumably, the new owner has assumed existing contractual rights and obligations, including those under the contract for submitting MDS information. All contractual agreements, regardless of their type, involving the MDS data should not violate the requirements of participation in the Medicare and/or Medicaid program, the Privacy Act of 1974 or any applicable State laws.

NURSING FACILITIES PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974. THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

 AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER OR NOT DISCLOSURE IS MANDATORY OR VOLUNTARY.

Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.

Medicare and Medicaid participating long-term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information also is used by the Federal Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. For this purpose, as of June 22, 1998, all such facilities are required to establish a database of resident assessment information, and to electronically transmit this information to the CMS contractor in the State government, which in turn transmits the information to CMS.

Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures.

These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS Long-Term Care System of Records.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

The information will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing facilities that participate in Medicare or Medicaid. Submission of MDS information may also be necessary for the nursing facilities to receive reimbursement for Medicare services.

3. ROUTINE USES

The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: To the Census Bureau and to: (1) Agency contractors, or consultants who have been engaged by the Agency to assist in accomplishment of a CMS function, (2) another Federal or State agency, agency of a State government, an agency established by State law, or its fiscal agent to administer a Federal health program or a Federal/State Medicaid program and to contribute to the accuracy of reimbursement made for such programs, (3) to Quality Improvement Organizations (QIOs) to perform Title XI or Title XVIII functions, (4) to insurance companies, underwriters, third party administrators(TPA), employers, self-insurers, group health plans, health maintenance organizations (HMO) and other groups providing protection against medical expenses to verify eligibility for coverage or to coordinate benefits with the Medicare program, (5) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health, or payment related projects, (6) to a member of Congress or congressional staff member in response to an inquiry from a constituent, (7) to the Department of Justice, (8) to a CMS contractor that assists in the administration of a CMS-administered health benefits program or to a grantee of a CMS-administered grant program, (9) to another Federal agency or to an instrumentality of any governmental jurisdiction that administers, or that has the authority to investigate potential fraud or abuse in a health benefits program funded in whole or in part by Federal funds to prevent, deter, and detect fraud and abuse in those programs, (10) to national accrediting organizations, but only for those facilities that these accredit and that participate in the Medicare program

4. EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

The information contained in the Long-Term Care Minimum Data Set is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, for example on medical history, inappropriate and potentially harmful care may result. Moreover, payment for such services by third parties, including Medicare and Medicaid, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

1.9 The Components of the Minimum Data Set (MDS)

Minimum Data Set

The MDS is completed on all residents in Medicare or Medicaid certified facilities. A mandated assessment schedule is discussed in Chapter 2. In addition, states may establish additional MDS requirements. For specific information on State requirements, contact your State RAI Coordinator (see Appendix B).

Since the requirements for Medicare PPS went into effect, assessments may be referred to as either a "comprehensive" or "full" assessment. To clarify this terminology, the comprehensive assessment is a clinical assessment that requires the full MDS, RAPs and Utilization Guidelines. Comprehensive assessments include all required MDS items (including State-designated sections), RAPs, and documentation in accordance with the Utilization Guidelines. Comprehensive assessments are required within 14 days of the admission, annually, when there has been a significant change in clinical status, and when the facility does a Significant Correction of a Prior Full assessment.

When the term "full assessment" is used, it includes the MDS required items A through R (plus any State-required items). A full assessment is distinguished from a comprehensive assessment (RAI) in that the RAPs and care planning are not completed when the full assessment is completed for a Medicare assessment.

Of course, the facility's right to care plan is not restricted to the RAI mandated requirements. Facilities may expand upon these requirements, when appropriate, to fully assess and care plan for an individual

The required components of the MDS are as follows:

SECTION AA - The Basic Assessment Tracking Form

This form contains Identification Information Items 1-9, which consists of identifying information needed to uniquely identify each resident, the nursing facility in which he or she resides, the reason(s) for assessment; and Items AA9 a-l, Signatures of Persons Completing a Portion of the MDS or Tracking form. The information contained on this form must accompany each comprehensive, full, MPAF, or Quarterly assessment, as well as every Distcharge and Reentry Tracking form, submitted electronically to the State MDS database. This includes Federally required assessment records, (e.g., Admission, Annual, Significant Change in Status, and Quarterly assessments), as well as assessments required for Medicare or by the State. This section also contains the Attestation Statement that staff members must sign and date attesting to the accuracy of the portions of the MDS completed by each member of the interdisciplinary team.

SECTIONS AB, AC, AD - Background (Face Sheet) Information at Admission Form

This form contains Sections AB (Demographic Information), Section AC (Customary Routine), and Section AD (Face Sheet Signatures). This information is to be completed at the

time of the resident's initial admission to the nursing facility. A new Face Sheet is also required to be completed, along with an Admission assessment, for an individual who returns to the facility after a discharge in which return was not anticipated. CMS's clinical policies, as well as data specifications, allow Face Sheet information to be updated and submitted after the Admission assessment is completed and transmitted. This means that Face Sheet information can be transmitted with any of the Federally required records (those indicated by the codes under AA8a) or the assessments required for Medicare (those indicated by the codes under AA8b). The only instance in which Face Sheet information cannot be updated is from those assessments required by the State (AA8a = "0" and AA8b = "6").

SECTIONS A-Q - Clinical Assessment

Sections A-Q contain the clinical data items used to assess residents in the nursing facility. Section A9 is where staff sign that they have completed portions of the assessment and agree to the Attestation Statement

SECTION R – Signature and Completion Date

Section R contains the signature of the RN coordinating the assessment. This is the section that records participation of the resident, family and/or significant other in the assessment process.

SECTION S - State Section

Some states have added items to the core MDS that must be completed for each resident when a comprehensive assessment, full, MPAF, or Quarterly is required. Thus, while the basic MDS form is the standard foundation for states, you may find that other items have been added at the end of the form (in Section S) in your state. Contact your State RAI Coordinator for Statespecific requirements. A list of State RAI Coordinators is found in the Appendix B.

SECTION T – Supplement

Required for all Medicare assessments. Optional at State discretion for all other types of assessments

SECTION U – Medications

Not used by CMS. Can be required by the State.

SECTION V - Resident Assessment Protocol Summary

Section V contains the form used to document triggered RAPs, the location of documentation describing the resident's clinical status and factors that impact the care planning decision, and whether or not a care plan has been developed for each RAP area. Note that the RAP need not have triggered for a care plan to be developed for that particular area. A RAP Summary form must be completed each time a comprehensive RAI is required under the Federal schedule. If a care plan is written from a non-triggered RAP, it should be noted on the RAP Summary form.

Quarterly Assessments

Additionally, states must specify a Quarterly assessment form, for use by facilities that includes at least the items on the CMS-designated form. The Quarterly assessment contains the mandated subset of MDS items from Section A (Identification and Background Information) through Section R (Assessment Information) that serves as the minimum requirement for Quarterly assessments within each State's RAI. Some states have mandated an expanded Optional Quarterly assessment form. CMS has published two optional versions that states may require. A state may also require a full assessment on a quarterly basis. Again, contact your State RAI Coordinator for State specifics. States have the following options for the Quarterly Assessment:

- Minimum Required MDS Quarterly Assessment
- MDS Quarterly Assessment Form Optional Version for RUG-III or Optional Version for RUG-III 1997 Update
- Full MDS Assessment
- Medicare Prospective Payment Assessment Form (MPAF)

Copies of the Quarterly assessment options available to the states are included at the end of this Chapter.

Discharge and Reentry Tracking Forms

Facilities are required to submit the information contained in two additional forms to notify the State if a resident is "discharged" or "reenters" the MDS system. Both the Discharge Tracking form and the Reentry Tracking form contain Section AA (Identification Information) Items 1-7, a subset of codes from Item 8 (Reason for Assessment), and Item 9. The Discharge Tracking form also contains items from Section R related to discharge status and date, along with two items from Section AB, that are required only for individuals whose stay is less than 14 days. The Reentry Tracking form contains items from Section A related to the date and point of reentry. States may opt to require Section S information to accompany Discharge and Reentry Tracking forms. A detailed discussion of the Discharge and Reentry Tracking process is in Chapter 2.

Medicare Assessments

Nursing facilities perform a comprehensive MDS assessment when the Medicare assessment is combined with any assessment required for clinical and/or care planning purposes, i.e., all OBRA assessments except the Quarterly. In 2002, a customized version of the MDS form was developed to minimize the facility's data collection requirements. This customized Medicare Prospective Payment System Assessment Form (MPAF) may be used when the assessment is performed solely for payment purposes (see Chapter 2 for details).

Resident Assessment Protocols (RAPs)

The **triggers** are specific resident responses for one or a combination of MDS elements. The triggers identify residents who either have or are at risk for developing specific functional problems and require further evaluation using Resident Assessment Protocols (RAPs) designated within the

State specified RAI. MDS item responses that define triggers are specified in each RAP and on the trigger legend form. Not all items assessed on the MDS are automatic triggers, e.g., use of side rails at P4. However, the RAP may be used to evaluate those items that are not automatic triggers. Turn to the RAPs (in Appendix C) to review these items and the accompanying RAP Guidelines. Once you are familiar with the RAP triggers and guidelines, the trigger legend form serves as a useful summary of all RAP triggers. The **trigger legend** summarizes which MDS item responses trigger individual RAPs and has been designed as a helpful tool for facilities if they choose to use it. **It is a worksheet, not a required form**, and does not need to be maintained in each resident's clinical record

The RAPs provide structured, problem-oriented frameworks for organizing MDS information, and additional clinically relevant information about an individual's health problems or functional status. What are the problems that require immediate attention? What risk factors are important? Are there issues that might cause you to proceed in an unconventional manner for the RAP in question? Clinical staffs are responsible for answering questions such as these. The information from the MDS and RAPs forms the basis for individualized care planning. The RAPs Summary form documents the decisions made during this evaluation process whether or not to proceed to care planning.

Utilization Guidelines

The **Utilization Guidelines** are instructions concerning when and how to use the RAI. Once a RAP has been triggered, use the utilization guidelines to evaluate the problem and determine whether or not you continue to care plan for it. The Utilization Guidelines for Version 2.0 of the RAI were published by CMS in the <u>State Operations Manual¹ Transmittal #272</u>, and are discussed in detail in Chapter 4.

The individual resident's care plan must be evaluated and revised, if appropriate, each time a comprehensive or Quarterly assessment is completed. Facilities may either make changes to the original care plan or develop a new care plan.

Additional information relevant to a resident's status, but not necessarily included on the RAI, may be documented in the resident's active record. This documentation should include progress notes or facility specific flow sheets.

1.10 Applicability of RAI to Facility Residents

The clinical requirements for the resident assessment instrument are found at 42 CFR 483.20 and are applicable to all residents in certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, or payment category.

¹The SOM is a reference only; it is not necessary for effective use of the RAI. The SOM can be ordered from the National Technical Information Service (NTIS); PB# 95-950007; (703) 487-4650.

An RAI <u>must</u> be completed for any resident residing in the facility **longer than 14 days**, including:

- All residents of Medicare (Title 18) skilled nursing facilities or Medicaid (Title 19) nursing facilities. This includes a certified Skilled Nursing Facility (SNF) or Nursing Facility (NF) and certified SNFs or NFs in hospitals, regardless of payment source.
- Hospice Residents. When an SNF or NF is the hospice patient's residence for purposes of the hospice benefit, the facility must comply with the requirements for participation in Medicare or Medicaid. This means the hospice resident must be assessed using the RAI, have a care plan and be provided with the services required under the plan of care. This can be achieved through cooperation between the hospice and long-term care facility staff with the consent of the resident. In these situations, the hospice team should participate in completing the RAI.
- Short-term stay or respite residents. An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long-term care facility for participation in the Medicare or Medicaid programs. If the respite resident is in a certified bed, you must follow the OBRA assessment schedule and tracking document requirements. If the respite resident is in the facility for fewer than 14 days, no assessment is due. Facilities that have short-term or respite residents should follow the instructions in Chapter 2 for completion of assessments and tracking forms.

Given the nature of short stay or respite admissions, staff members may not have access to all information required to complete some MDS items prior to the resident's discharge (e.g., the physician may not be available, or the family may not be able to provide information on the resident's Customary Routine). In that case, the "no-information" convention should be used ("-") (See Chapter 3 Section 3.2 for more information). For respite residents who come in and out of the facility on a relatively frequent basis and readmission can be expected, the resident may be discharged to "extended" leave status (Discharged-return anticipated). This status does not require reassessment each time the resident returns to the facility unless a significant change in the resident's status has occurred in the intervening period.

Regardless of the resident's length of stay, the facility must still have a process in place to identify the resident's needs, and must initiate a plan of care to meet the resident's needs upon or shortly after admission. In addition, if the resident is eligible for Medicare Part A benefits, a Medicare assessment will still be required to support payment under the SNF PPS.

- Special populations (e.g. pediatric or residents with a psychiatric diagnosis). Certified facilities are required to complete an RAI for all residents who reside in the facility, regardless of age or diagnosis.
- Long-Term Care Facilities. Additional assessments are required for Medicare beneficiaries in a SNF Part A stay. The MDS is used to determine the Resource Utilization Group (RUG-III) that is used to calculate payment under the SNF PPS. See Chapter 2 for detailed information on Medicare assessments.

Swing bed facilities. Swing bed hospitals providing Part A skilled nursing facility-level services were phased into the skilled nursing facility prospective payment system (SNF PPS) starting July 1, 2002. Beginning on the first day of each hospital's cost reporting year on and after July 1, 2002, swing bed hospitals must complete a customized two-page MDS assessment form that will be used to determine payment levels for Medicare beneficiaries. A separate Swing Bed MDS Assessment Training Manual has been developed and can be found on the CMS website at:

http://www.cms.hhs.gov/providers/snfpps/sbtraining.asp.

Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. This does not preclude a state from mandating the RAI for residents who live in these units. Please contact your State RAI Coordinator for State requirements. A list of RAI Coordinators can be found in Appendix B.

1.11 Facility Responsibilities for Completing Assessments

NEWLY CERTIFIED NURSING FACILITIES

Nursing facilities must admit residents and operate in compliance with certification requirements before a survey can be conducted. The OBRA assessments are a condition of participation and should be performed as if the beds were already certified. Then, assuming a survey where the SNF has been determined to be in substantial compliance, the facility will be certified effective on the last day of the survey. If the facility completed the Admission assessment prior to the certification date, there is no need to do another Admission assessment. The facility simply continues the OBRA schedule using the actual admission date as Day 1. NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue performing OBRA assessments according to the original schedule.

Medicare cannot be billed for any care provided prior to the certification date. Therefore, the facility must use the certification date as Day 1 (of the covered Part A stay) when establishing the Assessment Reference Date for the 5-Day Medicare assessments. For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. Assuming a survey where the SNF has been determined to be in substantial compliance, the SNF should implement the Medicare assessment schedule (for any resident in a bed that is pending certification) using the last day of the survey as Day 1.

If the SNF is already certified and is adding additional certified beds, the procedure for changing the number of certified beds is different from that of the initial certification. Medicare and Medicaid residents should not be placed in a bed until you are notified that the bed has been certified.

CHANGE IN OWNERSHIP

There are two types of change in ownership transactions. The more common situation requires the new owner to assume the assets and liabilities of the prior owner. In this case, the assessment

schedule for existing residents continues, but the facility uses the new provider number. For example, if the Admission assessment was done 10 days prior to the change in ownership, the next OBRA assessment would be due no later than 92 days from the MDS Completion Date (R2b) of the Admission assessment, and would be submitted using the new provider number. If the resident is in a Part A stay, and the 14-Day Medicare assessment was used as the OBRA Admission assessment, the next regularly scheduled Medicare assessment would be the 30-Day MDS, and would also be submitted under the new provider number.

There are situations where the new owner will not assume the assets and liabilities of the previous owner. In these cases, each resident is considered a new admission effective on the date of sale. New assessment schedules will be required for all residents in certified beds.

TRANSFERS OF RESIDENTS

Any time a resident is admitted to a new facility (regardless of whether or not it is a transfer within the same chain), a new comprehensive assessment must be done within 14 days. When transferring a resident, the transferring facility must provide the new facility with necessary medical records, including appropriate MDS assessments, to support the continuity of resident care. However, when the second facility admits the resident, the MDS schedule starts from the beginning with an Admission assessment, and if applicable, a 5-Day Medicare assessment. The admitting facility should of course look at the previous facility's assessment (in the same way they would review other incoming documentation about the resident) for the purpose of understanding the resident's history and promoting continuity of care. The admitting facility must perform a new assessment for the purpose of planning care within the facility to which the resident has been transferred. The only situation in which it would not make clinical sense to redo an assessment is when a "transfer" has occurred only on paper--that is, the name and provider number of a facility has changed, but the resident remains in the same physical setting under the care of the same staff. States may have other requirements from a payment perspective. Therefore, facilities should contact their survey agency as well for clarification.

In instances where there has been a massive transfer of new residents to a nursing facility secondary to natural disasters (flood, earthquake, fire), a new MDS must be completed by the admitting facility. The admitting facility should try to complete the MDS within 14 days of transfer if at all possible. If the admitting facility is having problems meeting the requirement they should contact their State agency to discuss the situation and receive guidance about any extensions in the 14-day time factor.

1.12 Completion of the RAI

PARTICIPANTS IN THE ASSESSMENT PROCESS

Federal regulations² require that the RAI assessment must be conducted or coordinated with the appropriate participation of health professionals. Although not required, completion of the RAI is best accomplished by an interdisciplinary team that includes facility staff with varied clinical

² 42 CFR 483.20 (h)--(F 278)

backgrounds. Such a team brings their combined experience and knowledge together for a better understanding of the strengths, needs and preferences of each resident to ensure the best possible quality of care and quality of life. In general, participation by all relevant interdisciplinary team members will encourage more active and appropriate assessment and care planning processes.

Facilities have flexibility in determining who should participate in the assessment process as long as it is accurately conducted. A facility may assign responsibility for completing the RAI to a number of qualified staff members. In most cases, participants in the assessment process are licensed health professionals. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment.

The RAI <u>must</u> be conducted or coordinated by an RN who signs and certifies the completion of the assessment³. If a facility does not have an RN on its staff (i.e., has an RN waiver granted under 42 CFR 483.30 (c) or (d) -- F354) it must still provide an RN to complete the RAI. This requirement can be met by hiring an RN specifically for this purpose. In this situation, the LPN responsible for the care of the resident should participate in the resident assessment process and the development of the resident's care plan.

The attending physician is also an important participant in the RAI process. The facility needs the physician's evaluation and orders for the resident's immediate care as well as for a variety of treatments and laboratory tests. Furthermore, the attending physician may provide valuable input on sections of the MDS and RAPs and is a member of the mandated interdisciplinary team that prepares the resident's comprehensive care plan.

While some aspects of the assessment process are dictated by regulation, much flexibility remains for facilities to determine how to integrate the RAI into their day-to-day operations. For example, facilities should develop their own policies and procedures to accomplish the following:

- Train facility staff on the circumstances that require a comprehensive assessment and the staff that should be involved.
- Assign responsibility for completing sections of the MDS to staff who have clinical knowledge about the resident, such as staff nurses, attending physicians, social workers, activities specialists, physical, occupational, or speech therapists, dietitians, and pharmacists.
- Assure that residents and their families are actively involved in the information sharing and decision-making processes.
- Assure that the care planning component is developed with input from all staff.
- Assure that key clinical personnel on all shifts (including nursing assistants) are knowledgeable about the information found in the resident's most current assessment and report changes in the resident's status that may affect the accuracy of this information or the need to perform a significant change reassessment.

³ 42 CFR 483.20 (i)(1)--(F 278)

• Instruct staff on how to integrate MDS information with existing facility resident assessment and care planning practices.

1.13 Sources of Information for Completion of the MDS

The process for performing an accurate and comprehensive assessment requires that information about residents be gathered from multiple sources. It is the role of the individual interdisciplinary team members completing the assessment to validate the information obtained from the resident, resident's family, or other health care team members through observation, interviewing, reviewing lab results, and so forth to ensure accuracy. Similarly, interacting with the resident and direct care staff validates information in the resident's record.

The following sources of information must be used in completing the MDS. Although not required, the review sequence for the assessment process generally follows the order below:

- **Review of the resident's record** Depending on whether or not the assessment is an admission or follow-up assessment, the review could include: preadmission, admission, or transfer notes; current plan of care; recent physician notes or orders; documentation of services currently provided; results of recent diagnostic or other test procedures; monthly nursing summary notes and medical consultations for the previous 60-day period; and a record of medications administered for the prior 30-day period.
- Communication with and observation of the resident.
- Communication with direct-care staff (e.g., nursing assistants, activity aides) from all shifts.
- Communication with licensed professionals (from all disciplines) who have recently observed, evaluated, or treated the resident. Communication can be based on discussion or licensed staff can be asked to document their impressions of the resident.
- Communication with the resident's physician.
- Communication with the resident's family Not all residents will have family. For some residents, family members may be unavailable or the resident may request that you not contact them. Where the family is not involved, the resident may request that someone else who is very close to him/her be contacted.

REVIEW OF THE RESIDENT'S RECORD

The resident's record provides a starting point in the assessment process to review information about the resident in written staff notes across all shifts over multiple days. Starting with the resident's record, however, does not indicate that it is the most critical source of information, but only a convenient source.

At admission, record review includes an examination of notes written in the first 2 weeks (assuming the full 14-day period is used to complete the assessment), documentation that came with the resident at admission, facility intake forms (e.g., social service notes), and any preadmission test results including copies of the MDS and RAPs from another nursing facility if the resident was transferred. Obviously, transcribing the previous facility's MDS is inappropriate.

Subsequent reassessments should focus on recorded information from earlier MDS assessments and Quarterly assessments, written information from the previous 3-month period, and notes made during the prior 30-day period.

The following are important considerations when reviewing the resident's record:

- Review the information documented in the record, keeping in mind the required MDS definitions. Make sure that assumptions based on the record are compatible with MDS definitions (e.g., resident self-performance is evaluated with appliances if used, such as locomotion with a walker; similarly, according to the MDS, a resident, who stays "dry" with a catheter may be considered continent).
- Make sure that the information taken from the record covers the same observation period as that specified by the MDS items. The MDS refers to specific time frames for each item; for example ADL status is based on resident performance over a 7-day period. To ensure uniformity, the MDS has an Assessment Reference Date (A3a) that establishes a common reference endpoint for all items. Consequently, it is necessary to pay careful attention to the notes regarding time frames for each section of the MDS and also to the Item-by-Item instructions in Chapter 3.
- Be aware of discrepancies and view the record information as preliminary only. Clarify and validate all such information during the assessment process. Be alert to information in the record that is not consistent with verbal information or physical assessment findings. Discuss discrepancies with other interdisciplinary team members (e.g., nurses, social workers, therapists). The extent to which the record can be relied upon for information will depend on the comprehensiveness of the record system. Note what information the record usually contains (e.g., current service notes, care plans, flow sheets, medication sheets), where different types of information are maintained in the clinical record, and more importantly, what information is missing.
- Where information in the record is sufficiently detailed and conforms to MDS descriptions and time periods, complete the MDS items. A few MDS items can be completed in full from information found in the record. Comprehensive and accurate assessment of most items, however, requires information from other sources (i.e., the resident, the resident's family, and facility staff). Where information is incomplete or contradictory, make a note of the issues in question. This note can help plan contacts with the resident, facility staff and resident's family. There is no requirement that such a note be maintained as part of the resident's permanent record; it is a suggested work tool only.
- As you observe, talk with, and discuss the resident with other staff members, verify the accuracy of what you learned from reviewing the record.

COMMUNICATION WITH AND OBSERVATION OF THE RESIDENT

The resident is a primary source of information and may be the only source of information for many items (e.g., customary routine, activity preferences, vision, hearing, identification with past roles, and, in some instances, problem conditions). Many MDS items will not be documented elsewhere in the clinical record, and the completed MDS may ultimately be the single source of documentation about these issues.

Become familiar with the MDS items to make communication and observation of the resident an ongoing everyday activity in the facility. For example, an RN can observe and interact with a resident when medications are given, during meals, or when the resident comes to ask a question. Interaction with the resident may be a crucial factor in confirming staff judgments of resident problems. Weigh what the resident says, and what is observed about the resident against other information obtained from the resident record and facility staff.

To be most efficient, organize a framework for how to interview and observe the resident. Allow flexibility to accommodate the resident. Carefully listen and observe the resident to get guidance as to how to pursue the necessary information gathering. Try to interact with the resident, even if the resident may have difficulty responding. The degree and character of the difficulty in responding, as well as nonverbal responses (e.g., fearfulness) provide important information. Sensitive staff judgment is necessary in gathering information. For further information on "Interviewing Techniques" see Appendix D.

It is important to observe, interview and physically assess the resident, and to interview staff. In addition, the MDS was designed to consider information obtained from family members, although it is not necessary that every discussion with them be face-to-face. Assessors should capture information that is based on what actually happened during the observation period, not what usually happens. Problems may be missed when the resident's actual status over the entire observation period is not considered.

Any person completing any MDS section is required to follow the Item-by-Item guidelines in Chapter 3 of this manual that specify sources of information necessary for accurate coding. The process of information gathering should include direct observation of the resident; communication with the resident's direct caregivers across all shifts; review of relevant information in the resident's clinical record; and if possible, consultation with family members who have direct knowledge of the resident's behavior in the observation period. If the person completing the MDS did not personally observe for example a behavior, but others report that it occurred, the behavior must be considered as having occurred when completing the MDS form. In addition, the resident's clinical record should support their status as reported on the MDS.

COMMUNICATION WITH DIRECT CARE STAFF

Direct care staff (e.g., nursing assistants and activity aides) having daily, intimate contact with residents is often the most reliable source of information about the resident. Direct care staff talk with and listen to the residents. They observe and assist the resident's performance of ADLs and involvement in activities. They observe the resident's physical, cognitive and psychosocial status

daily during all shifts, seven days a week. Key considerations when communicating with direct care staff are:

- Be sure to speak with a person who has first-hand knowledge of the resident. Plan for sufficient time to talk with direct care staff person(s).
- Start by asking about the resident's performance on ADLs and activities. What can the resident do without assistance? What do staff members do for the resident? What might the resident be able to do that he or she is not doing now? Continue by asking about communication and memory skills, body control, activity preferences, and the presence of mood or other behavioral symptoms.
- Talk with direct care staff across all shifts, if possible. The information from other shifts may be obtained in other ways as well (e.g., from change-of-shift reports if direct care staff comments are included).

COMMUNICATION WITH LICENSED PROFESSIONALS

Licensed practical nurses (LPNs), RNs, social workers, activities professionals, occupational therapists, physical therapists, speech therapists, pharmacists, dietitians, and other professionals who have observed, evaluated, or treated the resident should be interviewed about their knowledge of resident capabilities, performance patterns, and problems. Their special expertise will enhance the accuracy and comprehensiveness of the resident assessment.

COMMUNICATION WITH THE RESIDENT'S PHYSICIAN

The physician's role is central to the overall management and outcome of resident care. The MDS assessment process should include a review of the physician's examination of the resident, plan of care, hospital discharge plan, goals of care, and medication and treatment orders. At the Quarterly assessments and Annual assessments, review the most recent physician orders and notes. Also, review the MDS with the resident's attending physician to share and validate pertinent information. If there is difficulty obtaining information or input for the assessment from the attending physician (or transferring institution), the facility's medical director should be asked to intervene.

COMMUNICATION WITH THE RESIDENT'S FAMILY

The resident's family (or person closest to the resident) can be a valuable source of information about the resident's health history, history of strengths and problems in various functional areas, and customary routine prior to the first nursing facility admission. This information is particularly necessary when the resident is cognitively impaired or has a great deal of difficulty communicating. Using this source obviously depends on the presence of family members, their willingness to participate, and the resident's preferences. Facilities need to respect the cognitively intact resident's right to privacy, and should have permission from the individual for staff to ask questions of family members. In most instances, family will not be the sole source of information but will supplement

information from other sources. The assessment process provides an excellent opportunity for caregivers to develop trusting, working relationships with the resident and family.

1.14 CMS Clarification Regarding Documentation Requirements

CMS has always accepted the MDS as a primary data source, and duplicative documentation is not required. However, clinical documentation that furnishes a picture of the resident's care needs and response to treatment is an accepted standard of practice, is part of good resident care, and staff care planning. For this reason, it is always expected that information contained in the clinical record supports rather than conflicts with the MDS. Completion of the MDS does not remove the facility's responsibility to document a more detailed assessment of particular issues of relevance for the resident. In addition, for the Medicare prospective payment system, documentation must substantiate the resident's need for Part A SNF-level services and his/her response to those services.

Nursing facilities are required to document the resident's care and response to care during the course of the stay, and it is expected that this documentation would chronicle, support and be consistent with the findings of each MDS assessment. Always keep in mind that government requirements are not the only or even the major reason for clinical documentation. The MDS has simply codified some documentation requirements into a standard format.

Clinical documentation that contributes to identification and communication of residents' problems, needs and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and is an expectation of trained and licensed health care professionals. Good clinical practice has always dictated documentation of certain treatments and conditions such as the amount of IV nutrient intake and the number of minutes of therapy actually provided to a SNF resident. For these types of services, the more detailed documentation needed for good resident care also provides all the data needed to code the MDS. The MDS does not require duplication of the more detailed treatment logs; the data are simply summarized on the MDS.

In addition, it is important to note that CMS does not impose specific documentation procedures to nursing facilities. Some facilities have developed tools to collect data across shifts or throughout an assessment period; e.g., ADL support needs, type and duration of restorative nursing services, etc. Some facilities have found flow sheets useful for this purpose. The form and format of such documentation is determined by the facility. These tools may provide more accurate data for MDS reporting and care planning, and may provide real value to the facilities utilizing them. However, these tools are not mandated by CMS or by Fiscal Intermediaries.

When available, State agency and Fiscal Intermediary staff will utilize these data collection tools as part of an MDS validation review. In the absence of this type of documentation, the MDS can still be verified by a review of the entire record to verify that the medical record supports and is consistent with the responses on the MDS.

Some states may have regulations that require supporting documentation elsewhere in the record to substantiate the resident's status on particular MDS items used to calculate payment under the State's Medicaid system. If your state requires the MDS to be completed for the Medicaid program, they may have additional documentation requirements. Contact your State agency's Resident Assessment Coordinator or your Medicaid program for State-specific requirements.

1.15 RAI Completion Time Frames

ASSESSMENT COMPLETION TIME FRAMES

Each individual team member who completes a portion of the MDS assessment must sign and certify its accuracy. Each interdisciplinary team member who completes a portion of the MDS assessment signs, dates, and indicates the portion of the assessment he or she completed in AA9. This signature and date should reflect the date of the assessment and may be earlier than the date in R2b. The RN coordinator is required to sign R2b to certify that the MDS is complete. The RN coordinator must not sign and attest to completion of the assessment until all other individual team members participating in the assessment have finished their portions of the MDS. If the RN does all of the MDS, then the nurse alone would sign and be responsible for certifying accuracy and completeness. An assessment that was signed and dated by all assessors, but not by the RN coordinator, because the RN coordinator is no longer at the facility, should be signed and dated (with the date it is actually signed) by the current RN assessment coordinator.

RAPS COMPLETION TIME FRAMES

An RN coordinator must also sign and date the RAP Summary form at VB1 and VB2, the RAPs Completion Date, to signify completion of the RAI assessment. For the admission assessment, the RN coordinator must sign and date the RAP Summary form at VB1 and VB2 within 14 days of the resident's admission to the facility. There is no Federal requirement that each individual team member completing a RAP sign and date the RAP Summary form to certify its accuracy. It is assumed that other team members' documentation for a RAP will be signed wherever it appears in the clinical record. However, if desired, individual team members may indicate which RAP(s) they completed, list their credentials, and the date it was completed by signing the form wherever there is room to do so in a legible manner. The RN completing the RAP Summary form does not have to be the same RN who completed and signed the MDS assessment.

It is never permissible to certify or backdate RAI forms for another individual on the interdisciplinary team. If an individual who completed a portion of the MDS is not available to sign it, then another team member should review the information and sign the form. Facilities should establish a policy regarding accountability for the RAI when these situations occur.

⁴ 42 CFR 483.20 (i)(2)--(F 278)

⁵ 42 CFR 483.20 (i)(1)--(F 278)

CARE PLANNING COMPLETION TIME FRAMES

The facility has 7 days after completing the RAI (RAPs Completion Date (VB2)). The staff member entering the care planning decision information must also sign and date the RAP Summary form at VB3 and VB4, the Care Plan Completion Date.

1.16 Attestation Statement of Accuracy

The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS information is the basis for:

- The development of an individualized care plan for the resident occurs directly from responses entered on the MDS,
- Medicare Prospective Payment System,
- State Medicaid reimbursement programs,
- Quality monitoring activities such as the Quality Indicator (QI) Reports, the data driven survey and certification process, and the quality measures used for public reporting,
- Research, and
- Policy development.

Primary responsibility for accuracy lies with the person selecting the MDS item response. Each person completing a section of the MDS is required to sign the Attestation Statement (AA9, AD, and AT7) that reads:

"I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from Federal funds. I further understand that payment of such Federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf."

In addition, the RN coordinating the assessment must sign and date the MDS. The signature of the RN attests to the completeness of the document. Each staff member who completes any portion of the MDS must sign and date the MDS and indicate beside their signature which portions they completed. Two or more staff members can complete items within the same section of the MDS. The RN assessment coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. The RN assessment coordinator is not certifying the accuracy of assessments that were completed by other health professionals.

1.17 Correcting The MDS

Once completed, edited, and accepted into the MDS data repository, facilities may not "change" a previously completed MDS form as the resident's status changes during the course of the nursing facility stay. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is a part of the facility's responsibility to provide necessary care and services. However, it is important to remember that the electronic record submitted to and accepted into the MDS database is the legal assessment. Changes made to the electronic record after data transmission or to the paper copy maintained in the medical record are not recognized as proper corrections. The MDS correction process is described in Chapter 5.

However, several additional processes have been put into place to assure that the MDS data is accurate both at the facility and in the State MDS database:

- If an error is discovered within 7 days of the completion of an MDS and before submission to the State MDS database, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial, and date) and correction of the MDS record in the facility database. The resident's care plan should also be reviewed for any needed changes.
- Software used in the facility to encode the MDS must run all standard edits as defined in the data specifications released by CMS.
- Enhanced record rejection standards have been implemented in the State MDS database. If an MDS record contains responses that are out of range, e.g., a 4 is entered when only 0-3 are allowable responses for an item, or item responses are inconsistent, e.g., a skip pattern is not observed, the record is rejected. Inaccurate data is not added to the State MDS database.
- If an error is discovered in a record in the State MDS database, Modification or Inactivation procedures must be implemented by the facility to assure that the database information is corrected.
- Clinical corrections must also be undertaken as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the care needed. A Significant Change in Status assessment or a Significant Correction of a Prior assessment may be needed as well as corrections to the information in the State MDS database.

1.18 Reproduction and Maintenance of the Assessments

A hard copy of all MDS forms within the last 15 months, including the signatures of the facility staff attesting to the accuracy and completion of the records, must be maintained in the resident's clinical record. This applies to all nursing facilities.

Until such time as CMS adopts an electronic signature standard that is compatible with pending Health Insurance Standards Accountability Act (HIPAA) requirements for electronic signature, all facilities are required to sign and retain hard copies of the MDS. We understand that the industry is eager to use electronic signatures, and we are just as eager to enable that capability. We plan to implement this as soon as CMS adopts an electronic signature standard, and the standard system is upgraded to enable compliance.

There is no requirement to maintain two copies of the form in the resident's record (the hand-written and computer-generated MDS). Either a hand written or a computer-generated form is equally acceptable. It is required that the record be completed, signed, and dated within the regulatory time frames, and maintained for 15 months in the resident's active record. If changes are made after completion, those changes must be made to the MDS record, and indicated on the form using standard medical records procedure. It may also be appropriate to update the resident's care plan, based on the revised assessment record. Resident assessment forms must accurately reflect the resident's status, and agree with the record that is submitted to the CMS standard system at the state. Please see Chapter 5 for detailed instructions on correcting MDS data.

Facilities are required to maintain 15 months of assessment data in the resident's active clinical record according to CMS policy. This includes all MDS forms, RAP Summary forms and Quarterly assessments as required during the previous 15-month period. After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff or State agency surveyors. The **exception** is that face sheet information (Section AB, AC, and AD) must be maintained in the active record until the resident is permanently discharged.

The 15-month period for maintaining assessment data does not restart with each readmission to the facility. In some cases when a resident is out of the facility for a short period (i.e., hospitalization), the facility must close the record because of State bed hold policies. When the resident then returns to the facility and is "readmitted," the facility must open a new record. The facility may copy the previous RAI and transfer a copy to the new record. In this case, the facility should also copy the previous 15 months of assessment data and place it on the new record. Facilities may develop their own specific policies regarding how to handle readmissions, but the 15-month requirement for maintenance of the RAI data does not restart with each new admission.

In cases where the resident returns to the facility after a long break in care (e.g., 14½ months), staff may want to review the older record to familiarize themselves with the resident history and care needs. However, the decision on retaining the prior stay record in the current chart is a matter of facility policy rather than CMS requirements.

For additional information, refer to Resident Assessment Requirements for Long-Term Care Facilities in the Code of Federal Regulations at 42 CFR 483.20.

MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

2. GENDER® 1. Male 2. Female 3. BIRTHDATE®	U L		7. IDEI	THE ICAHON IN OR			
2. GENDER® 1. Male 2. Female 3. BIRTHDATE® 4. RACE/® ETHNICITY 3. Black, not of Hispanic origin 5. SOCIAL SECURITY® AND MEDICARE® NUMBERS® (Cin 11st box if non med. no.) 6. FACILITY PROVIDER NO.® 7. MEDICAID NO. ["+" if pending, "w" if not a Medicaid recipient[9] Ment of the specific origin in the	1.						
3. BIRTHDATE® Month Day Year 4. RACE/® 1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 5. SOCIAL SECURITY® AND MEDICARE NUMBERS® IC in 1st box if non med. no.] 6. FACILITY PROVIDER NO.® 7. MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] 8. REASONS FOR ASSESS-MENT 1. Admission assessment 1. Admission assessment 2. Asignificant correction of prior full assessment 1. Significant correction of prior quarterly assessment 2. Medicare 30 day assessment 3. Medicare 50 day assessment 4. Medicare 60 day assessment 3. Medicare 60 day assessment 4. Medicare 60 day assessment 3. Medicare 60 day assessment 4. Medicare 60 day assessment 5. Medicare 60 day assessment 6. Medicare 60 day assessment 6. Medicare 60 day assessment 7. Medicare 60 day assessment 7. Medicare 60 day assessment 7. Medicare 60 day assessment 8. Medicare 60 day assessment			a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)	
4. RACE/® 1. American Indian/Alaskan Native 2. Asian/Pacific Islander 5. White, not of Hispanic origin 5. SOCIAL 3. Black, not of Hispanic origin 4. Hispanic origin 6. SOCIAL 5. SOCIAL 5. SOCIAL 6. SOCIAL 6. SOCIAL 7. SOCIAL 7	2.	GENDER*	1. Male	1. Male 2. Female			
4. RACE/® ETHNICITY ETHNICITY ETHNICITY 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 5. SOCIAL SECURITY® AND MEDICARE NUMBERS® [C in 18" box if non med. no.] 6. FACILITY PROVIDER NO.® 7. MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] ® 8. REASONS FOR ASSESS-MENT 8. REASONS FOR ASSESS-MENT 1. Admission assessment 2. Significant conrection of prior full assessment 3. Significant correction of prior quarterly assessment 1. Significant correction of prior quarterly assessment 2. Medicare 30 day assessment 3. Medicare 60 day assessment 3. Medicare 60 day assessment 4. Medicare 60 day assessment 5. White, not of 5. White, not of Hispanic 5. White, not of Hispanic origin 5. White, not of Hispanic origin 6. Hispanic 5. White, not of Hispanic origin 6. Hispanic 5. White, not of Hispanic origin 6. Not of Hispanic origin 6. Hispanic 5. White, not of Hispanic origin 6. Medicare 1. Acmission or comparable railroad insurance number) 6. Medicare 1. Acmission and insurance number) 7. Medicare 1. Acmission assessment 8. Reasons For a Medicare 1. Acmission assessment 9. Codes for assessment required for Medicare PPS or the State 9. Medicare 30 day assessment 9. Medicare 60 day assessment 9. Medicare 60 day assessment 9. Medicare 50 day assessment	3.	BIRTHDATE®	Mo	Donth Day	Year		
5. SOCIAL SECURITY AND MEDICARE NUMBERS© [C in 1s box if non med. no.] 6. FACILITY PROVIDER NO. 1. MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] © 8. REASONS FOR ASSESS- MENT 8. PRASSESS- MENT 1. Admission assessment 1. Admission assessment 1. Significant correction of prior full assessment 1. Significant correction of prior quarterly assessment 1. Significant correction of prior quarterly assessment 1. NONE OF ABOVE b. Codes for assessment required for Medicare PPS or the State 1. Medicare 30 day assessment 2. Medicare 60 day assessment 3. Medicare 60 day assessment	4.		1. Americ 2. Asian/F	an Indian/Alaskan Native Pacific Islander	4. Hispanic 5. White, not of		
non med. no.] 6. FACILITY PROVIDER NO. b. Federal No. 7. MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] © 8. REASONS FOR ASSESS-MENT 8. Significant corection of prior full assessment 1. Admission assessment (required by day 14) 2. Annual assessment 4. Significant correction of prior full assessment 10. Significant correction of prior quarterly assessment 10. NONE OF ABOVE b. Codes for assessment required for Medicare PPS or the State 1. Medicare 30 day assessment 2. Medicare 60 day assessment 3. Medicare 60 day assessment 3. Medicare 60 day assessment	5.	SECURITY® AND MEDICARE NUMBERS®	a. Social S	Security Number — — — —		n	
PROVIDER NO. b. Federal No. 7. MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] 0 8. REASONS FOR ASSESS-MENT 8. PRESSS INT 8. REASONS FOR ASSESS-MENT 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant correction of prior full assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE b. Codes for assessments required for Medicare PPS or the State 1. Medicare 30 day assessment 2. Medicare 60 day assessment 3. Medicare 60 day assessment							
7. MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] 8. REASONS FOR ASSESS-MENT 1. Admission assessment (required by day 14) 2. Annual assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 10. NONE OF ABOVE b. Codes for assessments required for Medicare PPS or the State 1. Medicare 30 day assessment 2. Medicare 60 day assessment 3. Medicare 60 day assessment	6.	PROVIDER	a. State N	lo.			
NO. ["+" if pending, "N" if not a Medicaid recipient] 8. REASONS FOR ASSESS-MENT 1. Admission assessment (required by day 14) 2. Annual assessment (required by day 14) 3. Significant correction of prior full assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE b. Codes for assessments required for Medicare PPS or the State 1. Medicare 30 day assessment 2. Medicare 60 day assessment 3. Medicare 60 day assessment			b. Federa	il No.			
FOR ASSESS- MENT a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE b. Codes for assessments required for Medicare PPS or the State 1. Medicare 5 day assessment 2. Medicare 60 day assessment 3. Medicare 60 day assessment	7.	NO. ["+" if pending, "N" if not a Medicaid					
Medicare readmission/return assessment Medicare readmission/return assessment Medicare 14 day assessment Medicare 14 day assessment Medicare required assessment	8.	REASONS FOR ASSESS- MENT	a. Primar 1. Adr 2. Ann 3. Sigu 4. Sigu 6. Oth 6. Oth 7. Med 6. Oth 7. Med	y reason for assessment mission assessment (required by usal assessment infificant change in status assessr infificant change in status assessr infificant correction of prior full assarterly review assessment infificant correction of prior quarter INE OF ABOVE as for assessments required for dicare 5 day assessment dicare 30 day assessment dicare 60 day assessment dicare eadmission/return assessment assessment assessment dicare 14 day assessment dicare 14 day assessment dicare 14 day assessment	v day 14) ment sessment rly assessment * Medicare PPS or the	State	

_	
9.	Signatures of Persons who Completed a Portion of the Accompanying Assessment o
	F
	Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
j.		
k.		
I.		

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

Resident Numeric Identifier

MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1.	DATE OF	Date the stay began. Note — Does not include readmission if record w				
	ENTRY	closed at time of temporary discharge to hospital, etc. In such cases, us admission date	se prior			
		Month Day Year				
2.	ADMITTED	Private home/apt, with no home health services				
	FROM (AT ENTRY)	Private home/apt. with home health services Board and care/assisted living/group home				
	,	4. Nursing home 5. Acute care hospital				
		6. Psychiatric hospital, MR/DD facility				
		7. Rehabilitation hospital 8. Other				
3.	LIVED	0. No				
	ALONE (PRIOR TO	1. Yes				
_	ENTRY)	2. In other facility				
4.	ZIP CODE OF PRIOR					
	PRIMARY RESIDENCE					
5.	RESIDEN- TIAL	(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)				
	HISTORY 5 YEARS	Prior stay at this nursing home				
	PRIOR TO	Stay in other nursing home	a.			
	ENTRY	Other residential facility—board and care home, assisted living, group	b.			
		home	c.			
		MH/psychiatric setting	d.			
		MR/DD setting	e.			
		NONE OF ABOVE	f.			
6.	LIFETIME OCCUPA-					
	TION(S)					
	[Put "/" between two					
	occupations]					
7.	EDUCATION (Highest	1. No schooling 5. Technical or trade school 2. 8th grade/less 6. Some college				
	Level	3. 9-11 grades 7. Bachelor's degree				
8.	Completed)	4. High school 8. Graduate degree (Code for correct response)				
		a. Primary Language				
		0. English 1. Spanish 2. French 3. Other				
		b. If other, specify				
9.	MENTAL	Does resident's RECORD indicate any history of mental retardation,				
	HEALTH HISTORY	mental illness, or developmental disability problem? 0. No 1. Yes				
10.	CONDITIONS	(Check all conditions that are related to MR/DD status that were				
	RELATED TO MR/DD	manifested before age 22, and are likely to continue indefinitely)				
	STATUS	Not applicable—no MR/DD (Skip to AB11)	a.			
		MR/DD with organic condition				
		Down's syndrome	b.			
		Autism	c.			
		Epilepsy	d.			
		Other organic condition related to MR/DD	e.			
		MR/DD with no organic condition	f.			
11.	DATE BACK-					
	GROUND					
	INFORMA- TION	Month Day Year				
1	COMPLETED					

SECTION AC CUSTOMARY ROUTINE

ECTION A	C. CUSTOMARY ROUTINE	
CUSTOMARY	(Check all that apply. If all information UNKNOWN, check last box on	ly.)
	CYCLE OF DAILY EVENTS	
(In year prior to DATE OF ENTRY	Stays up late at night (e.g., after 9 pm)	a.
to this nursing	Naps regularly during day (at least 1 hour)	b.
home, or year last in	Goes out 1+ days a week	c.
community if now being	Stays busy with hobbies, reading, or fixed daily routine	d.
admitted from another	Spends most of time alone or watching TV	e.
nursing home)	Moves independently indoors (with appliances, if used)	f.
	Use of tobacco products at least daily	g.
	NONE OF ABOVE	h.
	EATING PATTERNS	
	Distinct food preferences	i.
	Eats between meals all or most days	j.
	Use of alcoholic beverage(s) at least weekly	k.
	NONE OF ABOVE	I.
	ADL PATTERNS	
	In bedclothes much of day	m.
	Wakens to toilet all or most nights	n.
	Has irregular bowel movement pattern	о.
	Showers for bathing	p.
	Bathing in PM	q.
	NONE OF ABOVE	r.
	INVOLVEMENT PATTERNS	
	Daily contact with relatives/close friends	s.
	Usually attends church, temple, synagogue (etc.)	t.
	Finds strength in faith	u.
	Daily animal companion/presence	v.
	Involved in group activities	w.
	NONE OF ABOVE	x.
	UNKNOWN—Resident/family unable to provide information	y.

	Daily animal companion/presence		V.
	Involved in group activities		w.
	NONE OF ABOVE		x.
	UNKNOWN—Resident/family unable to	provide information	у.
	ECTION AD. FACE SHEET SIGNATURES OF PERSONS COMPLETING FACE SI		
a. Si	ignature of RN Assessment Coordinator		Date
appl basi from patic ness subs	is specified. To the best of my knowledge, this informati licable Medicare and Medicaid requirements. I understa is for ensuring that residents receive appropriate and qua nederal funds. I further understand that payment of such on in the government-funded health care programs is con is of this information, and that I may be personally subject stantial criminal, civil, and/or administrative penalties fo fy that I am authorized to submit this information by this	nd that this information is us ality care, and as a basis for p of federal funds and continued ditioned on the accuracy and to or may subject my organia or submitting false information	sed as a payment d partici- truthful- zation to
S	ignature and Title	Sections	Date
b.			
C.			
d.			
е.			
f.			
g.			
s		MDS 2.0 Septemb	er, 2000
es		WIDO 2.0 COPICITIE	701, 20

Resident ______ Numeric Identifier_

MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING FULL ASSESSMENT FORM

(Status in last 7 days, unless other time frame indicated)

SEC	CTION A.	IDENTIFICATION AND BACKGROUND INFORMA	TION 3		(Check all that resident was normally able to recall during
1.	RESIDENT NAME			RECALL ABILITY	last 7 days) Current season a
	INAIVIL	a. (First) b. (Middle Initial) c. (Last) d. (.	Jr/Sr)		Location of own room b. That he/she is in a nursing home
2.	ROOM	a. (1 1131) b. (Wildele Hillian) c. (East) c. (E	51/01/		Staff names/faces c. NONE OF ABOVE are recalled e.
	NUMBER		4.	COGNITIVE SKILLS FOR	(Made decisions regarding tasks of daily life)
3.	ASSESS-	a. Last day of MDS observation period		DAILY DECISION-	INDEPENDENT—decisions consistent/reasonable MODIFIED INDEPENDENCE—some difficulty in new situations
	MENT REFERENCE			MAKING	only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision
	DATE	Month Day Year			required 3. SEVERELY IMPAIRED—never/rarely made decisions
		b. Original (0) or corrected copy of form (enter number of correction)	5	INDICATORS	
١.	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospit last 90 days (or since last assessment or admission if less than 90	al in	OF DELIRIUM— PERIODIC	requires conversations with staff and family who have direct knowled of resident's behavior over this time].
		Month Day Year		DISOR- DERED THINKING/ AWARENESS	Behavior not present Behavior present, not of recent onset Behavior present, over last 7 days appears different from resident's usua functioning (e.g., new onset or worsening)
5.	MARITAL STATUS	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated		AVAILENESS	a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
6.	MEDICAL RECORD	2. Walled 4. Separated			b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not
·.	NO. CURRENT	(Billing Office to indicate; check all that apply in last 30 days)			present; believes he/she is somewhere else; confuses night and day)
	PAYMENT SOURCES FOR N.H.	0 1	f.		EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
	STAY	Medicare ancillary Medicaid resident liability or Medicare	g. h.		d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
		Medicare ancillary part B CHAMPUS per diem d. Private insurance per diem (including co-payment) Other per diem	i.		e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
3.	REASONS FOR	Rrimary reason for assessment Admission assessment (required by day 14)	J.		f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)
	ASSESS- MENT [Note—If this	Annual assessment Significant change in status assessment Significant correction of prior full assessment Quarterly review assessment	6.	CHANGE IN COGNITIVE STATUS	Resident's cognitive status, skills, or abilities have changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated
ľ	is a discharge or reentry assessment,	6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment	SF	CTION C (COMMUNICATION/HEARING PATTERNS
	only a limited	9. Reentry			(With hearing appliance, if used)
	subset of MDS items	Significant correction of prior quarterly assessment NONE OF ABOVE	•	TILARINO	0. HEARS ADEQUATELY—normal talk, TV, phone
	need be completed]	b. Codes for assessments required for Medicare PPS or the State 1. Medicare 5 day assessment 2. Medicare 30 day assessment			MINIMAL DIFFICULTY when not in quiet setting HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly
		3. Medicare 60 day assessment	2	COMMUNI-	3. HIGHLY IMPAIRED/absence of useful hearing (Check all that apply during last 7 days)
		4. Medicare 90 day assessment 5. Medicare readmission/return assessment		CATION	Hearing aid, present and used a.
		6. Other state required assessment		DEVICES/ TECH-	Hearing aid, present and not used regularly b.
		7. Medicare 14 day assessment 8. Other Medicare required assessment		NIQUES	Other receptive comm. techniques used (e.g., lip reading)
1	RESPONSI-	(Check all that apply) Durable power attorney/financial	d.		NONE OF ABOVE
	BILITY/ LEGAL	Legal guardian a. Family member responsible	e. 3	MODES OF EXPRESSION	(Check all used by resident to make needs known) Signs/gestures/sounds
	GUARDIAN	b. Patient responsible for self	f.		Speech a. Oigne goodares counted d.
		ottorner/health care	g.		Writing messages to express or clarify needs b. Communication board e.
1	ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical	9.		American sign language Other
I	DIILOTIVEO	Living will a. Feeding restrictions	f. 4	MAKING	or Braille c. NONE OF ABOVE g. (Expressing information content—however able)
		Do not resuscitate b. Medication restrictions		SELF	0. UNDERSTOOD
		C. Other treatment restrictions	g.	UNDER- STOOD	USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts
		Organ donation Autopsy request e. NONE OF ABOVE	h. i		SOMETIMES UNDERSTOOD—ability is limited to making concrete requests
		0			3. RARELY/NEVER UNDERSTOOD
_,	TION D	COONITIVE DATTERNIO	5	SPEECH CLARITY	(Code for speech in the last 7 days)
=(-		COGNITIVE PATTERNS (Persistent vegetative state/no discernible consciousness)			O. CLEAR SPEECH—distinct, intelligible words 1. UNCLEAR SPEECH—slurred, mumbled words 2. NO SPEECH—absence of spoken words
	COMMIUSE	0. No 1. Yes (If yes, skip to Section G)	6	ABILITYTO	2. NO SPEECH—absence of spoken words (Understanding verbal information content—however able)
2.	MEMORY	(Recall of what was learned or known)		UNDER- STAND	0. UNDERSTANDS
		Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem		OTHERS	USUALLY UNDERSTANDS—may miss some part/intent of message
		b. Long-term memory OK—seems/appears to recall long past			SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication
1		0. Memory OK 1. Memory problem		CHANGE IN	RARELY/NEVER UNDERSTANDS Resident's ability to express, understand, or hear information has
			'	COMMUNI-	changed as compared to status of 90 days ago (or since last assessment if less than 90 days)
				CATION/ HEARING	0. No change 1. Improved 2. Deteriorated

SECTION D. VISION PATTERNS

1.	VISION	(Ability to see in adequate light and with glasses if used)	
		O. ADEQUATE—sees fine detail, including regular print in newspapers/books I. IMPAIRED—sees large print, but not regular print in newspapers/books D. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects J. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects SEVERELY IMPAIRED—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes NONE OF ABOVE	а. b. с.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

		riasnes or light; sees "curtains" over	eyes	b.
		NONE OF ABOVE		c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying 0. No 1. Yes	glass	
SE	CTION E. M	OOD AND BEHAVIOR PAT	TERNS	
1.	INDICATORS OF DEPRES- SION, ANXIETY.	(Code for indicators observed in assumed cause) 0. Indicator not exhibited in last 30 d 1. Indicator of this type exhibited up 2. Indicator of this type exhibited dai	ays to five days a week	k)
	SAD MOOD	VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be	h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions	
		dead; What's the use; Regrets having lived so long; Let me die" b. Repetitive questions—e.g.,	i. Repetitive anxious complaints/concerns (non- health related) e.g., persistently seeks attention/ reassurance regarding	
		"Where do I go; What do I do?" c. Repetitive verbalizations—	schedules, meals, laundry, clothing, relationship issues SLEEP-CYCLE ISSUES	
		e.g., calling out for help, ("God help me")	j. Unpleasant mood in morning k. Insomnia/change in usual	3
		d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home;	sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE	
		e. Self deprecation—e.g., "I am nothing; I am of no use	Sad, pained, worried facial expressions—e.g., furrowed brows	
		f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others	m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking	
		g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	Note that a contract of the contract of t	
2.	MOOD PERSIS- TENCE	One or more indicators of depress not easily altered by attempts to "the resident over last 7 days 0. No mood 1. Indicators pres indicators easily altered	ed, sad or anxious mood were cheer up", console, or reassure	
3.	CHANGE IN MOOD	Resident's mood status has changed days ago (or since last assessment 0. No change 1. Improved	d as compared to status of 90 if less than 90 days)	
4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequence 0. Behavior not exhibited in last 7 1. Behavior of this type occurred 2 2. Behavior of this type occurred 2 3. Behavior of this type occurred 6	days I to 3 days in last 7 days I to 6 days, but less than daily	
		(B) Behavioral symptom alterabilit 0. Behavior not present OR behavand 1. Behavior was not easily altered	vior was easily altered (A	(B)
		 a. WANDERING (moved with no rat oblivious to needs or safety) b. VERBALLY ABUSIVE BEHAVIO 		
		were threatened, screamed at, cu c. PHYSICALLY ABUSIVE BEHAVI	ORAL SYMPTOMS (others	+
		were hit, shoved, scratched, sexual d. SOCIALLY INAPPROPRIATE/DISYMPTOMS (made disruptive so self-abusive acts, sexual behavior smeared/threw food/feces, hoardibelongings)	SRUPTIVE BEHAVIORAL unds, noisiness, screaming, or disrobing in public,	
		e. RESISTS CARE (resisted taking assistance, or eating)	medications/ injections, ADL	

5. CHANGE IN Resident's behavior status has changed as compared to status of 90 BEHAVIORAL days ago (or since last assessment if less than 90 days) SYMPTOMS 0. No change 1. Improved 2. Deteriorated

SECTION F. PSYCHOSOCIAL WELL-BEING

		TO TO TO THE THE PERIOD	
1.	SENSE OF	At ease interacting with others	a.
	INITIATIVE/ INVOLVE-	At ease doing planned or structured activities	b.
	MENT	At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED	Covert/open conflict with or repeated criticism of staff	a.
	RELATION- SHIPS	Unhappy with roommate	b.
	эпігэ	Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	С.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS 1. (A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL

٠.	SHIFTS	luring last 7 days—Not including setup)	1		
	INDEPENDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days				
	last7 days	SION—Oversight, encouragement or cueing provided 3 or more times —OR— Supervision (3 or more times) plus physical assistance provi s during last 7 days	durir ded o	ng only	
	guided ma	ASSISTANCE—Resident highly involved in activity; received physical ineuvering of limbs or other nonweight bearing assistance 3 or more tiellelp provided only 1 or 2 times during last 7 days	help i mes-	n -	
	period, he —Weight-	VE ASSISTANCE—While resident performed part of activity, over last p of following type(s) provided 3 or more times: bearing support ff performance during part (but not all) of last 7 days	7-day	y	
	4. TOTAL DE	EPENDENCE—Full staff performance of activity during entire 7 days			
	8. ACTIVITY	DID NOT OCCUR during entire 7 days			
	`´OVER ALI	PORT PROVIDED—(Code for MOST SUPPORT PROVIDED L SHIFTS during last 7 days; code regardless of resident's self-	(A)	(B)	
	O. No setup of Setup help One perso	ce classification) or physical help from staff only n physical assist 8. ADL activity itself did not ons physical assist occur during entire 7 days	SELF-PERF	SUPPORT	
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed			
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)			
c.	WALK IN ROOM	How resident walks between locations in his/her room			
d.	WALK IN CORRIDOR	How resident walks in corridor on unit			
e.	LOCOMO- TION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair			
f.	LOCOMO- TION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair			
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing , including donning/removing prosthesis			
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)			
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal);			
"	IOILET USE	transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes			

How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)

PERSONAL HYGIENE

2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) Code for most dependent in self-performance and support.						
		(A) BATHING SELF-PERFORMANCE codes appear below (A) (B)						
		Independent—No help provided Supervision—Oversight help only						
		Physical help limited to transfer only						
		Physical help in part of bat Tatal dependence.	hing act	ivity				
		Total dependence Activity itself did not occur	durina e	entire 7 days				
		(Bathing support codes are as	defined	in Item 1, code B above)				
3.	TEST FOR BALANCE	(Code for ability during test in to 0. Maintained position as requi						
	(see training manual)	 Unsteady, but able to rebala Partial physical support duri or stands (sits) but does not 	nce self ng test; follow d	without physical support irections for test				
		Not able to attempt test with Balance while standing	out phys	sical help				
		b. Balance while sitting—positi	on, trun	control				
4.	FUNCTIONAL	(Code for limitations during las	t 7 days	that interfered with daily function	ons or			
		placed resident at risk of injury (A) RANGE OF MOTION)	(B) VOLUNTARY MOVEMEN	IT			
	MOTION	No limitation Limitation on one side		 No loss Partial loss 	(4) (5)			
	(see training manual)	Limitation on both sides a. Neck		2. Full loss	(A) (B)			
		b. Arm—Including shoulder or						
		c. Hand—Including wrist or fing d. Leq—Including hip or knee	gers	-				
		e. Foot—Including ankle or toe	s					
		f. Other limitation or loss						
5.	MODES OF LOCOMO-	(Check all that apply during la Cane/walker/crutch		, ,				
	TION	Wheeled self	a. b.	Wheelchair primary mode of locomotion	d.			
		Other person wheeled	C.	NONE OF ABOVE	e.			
6.	MODES OF TRANSFER	(Check all that apply during la	ast 7 da	ys)				
	IKANSFER	Bedfast all or most of time	a.	Lifted mechanically	d.			
		Bed rails used for bed mobility or transfer	b.	Transfer aid (e.g., slide board, trapeze, cane, walker, brace)	e.			
		Lifted manually	c.	NONE OF ABOVE	f.			
7.	TASK SEGMENTA- TION	Some or all of ADL activities w days so that resident could pe 0. No 1. Yes	rform th					
8.	ADL FUNCTIONAL REHABILITA-	Resident believes he/she is ca least some ADLs	pable of	increased independence in at	а.			
	TION POTENTIAL	Direct care staff believe resider in at least some ADLs	nt is cap	able of increased independence	b .			
		Resident able to perform tasks		•	C.			
		Difference in ADL Self-Perform mornings to evenings	ance or	ADL Support, comparing	d.			
		NONE OF ABOVE			e.			
9.	CHANGE IN ADL FUNCTION	Resident's ADL self-performar to status of 90 days ago (or sidulys)						
			oroved	2. Deteriorated				
SE	CTION H. C	ONTINENCE IN LAST 1	4 DAY	S				
1.		SELF-CONTROL CATEGOR dent's PERFORMANCE OVE		CHIETS				
	0. CONTINEN	T—Complete control [includes does not leak urine or stool]		•	omy			
		CONTINENT—BLADDER, incomes than weekly	ntinent e	episodes once a week or less;				
		SIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; L, once a week						
		TLY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL,			me			
		ENT—Had inadequate control E (or almost all) of the time						
a.	BOWEL CONTI- NENCE	Control of bowel movement, w programs, if employed	ith appli	ance or bowel continence				
b.	BLADDER CONTI- NENCE	Control of urinary bladder functions soak through underpants), with programs, if employed						
2.	BOWEL ELIMINATION	Bowel elimination pattern regular—at least one	2	Diarrhea	C.			
	PATTERN	movement every three days	a.	Fecal impaction	d.			
		Constipation	b.	NONE OF ABOVE	e.			

3.	APPLIANCES AND	Any scheduled toileting pla	n a.	Did not use toilet room/	f.	
	PROGRAMS	Bladder retraining program	b.	Pads/briefs used	g.	
		External (condom) cathete	r c.	Enemas/irrigation	h.	
		Indwelling catheter	d.	Ostomy present	i.	
		Intermittent catheter	e.	NONE OF ABOVE	j.	
4.	CHANGE IN URINARY CONTI-	Resident's urinary contine 90 days ago (or since last		anged as compared to status of nt if less than 90 days)		
	NENCE	0. No change 1	.Improved	2. Deteriorated		
SECTION I. DISEASE DIAGNOSES						

inac	tive diagnoses)	otatao, modioar troatmonto, nai	- 3	3, 1 1 1 1 1 1 1 1	
1.	DISEASES	(If none apply, CHECK the N	ONE OI	FABOVE box)	
		ENDOCRINE/METABOLIC/		Hemiplegia/Hemiparesis	v.
		NUTRITIONAL		Multiple sclerosis	w.
		Diabetes mellitus	a.	Paraplegia	x.
		Hyperthyroidism	b.	Parkinson's disease	у.
		Hypothyroidism	c.	Quadriplegia	z.
		HEART/CIRCULATION		Seizure disorder	aa.
		Arteriosclerotic heart disease (ASHD)	d.	Transient ischemic attack (TIA)	bb.
		Cardiac dysrhythmias	e.	Traumatic brain injury PSYCHIATRIC/MOOD	CC.
		Congestive heart failure	f.	Anxiety disorder	
		Deep vein thrombosis	g.	Depression	dd.
		Hypertension	h.		ee.
		Hypotension	i.	Manic depression (bipolar disease)	ff.
		Peripheral vascular disease	i.	Schizophrenia	
		Other cardiovascular disease	k.	PULMONARY	gg.
		MUSCULOSKELETAL		Asthma	hh.
		Arthritis	I.	Emphysema/COPD	ii.
		Hip fracture	m.	SENSORY	
		Missing limb (e.g., amputation)		Cataracts	jj.
		Osteoporosis	о.	Diabetic retinopathy	kk.
		Pathological bone fracture	p.	Glaucoma	II.
		NEUROLOGICAL		Macular degeneration	mm.
		Alzheimer's disease	q.	OTHER	
		Aphasia	r.	Allergies	nn.
		Cerebral palsy	s.	Anemia	00.
		Cerebrovascular accident		Cancer	pp.
		(stroke)	t.	Renal failure	qq.
		Dementia other than Alzheimer's disease	u.	NONE OF ABOVE	rr.
2.	INFECTIONS	(If none apply, CHECK the N	ONE O	F ABOVE box)	
		Antibiotic resistant infection		Septicemia	g.
		(e.g., Methicillin resistant	a.	Sexually transmitted diseases	h.
		staph)	b.	Tuberculosis	i.
		Clostridium difficile (c. diff.) Conjunctivitis		Urinary tract infection in last 30	
		HIV infection	C.	days	J.
		Pneumonia	d.	Viral hepatitis	k.
			e.	Wound infection	I.
		Respiratory infection	f.	NONE OF ABOVE	m.
3.	OTHER CURRENT	a		•	
	OR MORE	b.			
	DETAILED DIAGNOSES	С.			
	AND ICD-9	d.			
	CODES				
		e			
SEC	TION I HE	ALTH CONDITIONS			

SECTION J. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	(Check all problems present in last 7 days unless other time frame is indicated)				
		INDICATORS OF FLUID		Dizziness/Vertigo	f.	
		STATUS		Edema	g.	
		Weight gain or loss of 3 or		Fever	h.	
		more pounds within a 7 day		Hallucinations	i.	
		period	a.	Internal bleeding		
		Inability to lie flat due to shortness of breath	b.	Recurrent lung aspirations in last 90 days	k.	
		Dehydrated; output exceeds		Shortness of breath	l.	
		input	C.	Syncope (fainting)	m.	
		Insufficient fluid; did NOT consume all/almost all liquids		Unsteady gait	n.	
		provided during last 3 days	d.	Vomiting	0.	
		OTHER		NONE OF ABOVE	p.	
		Delusions	e.			

		(0 1 12 14 14 14 14 14 14				
2.	PAIN	(Code the highest level of pain present in the last 7 days)				
	SYMPTOMS	a. FREQUENCY with which		b. INTENSITY of pain		
		resident complains or shows evidence of pain		1. Mild pain		
		0. No pain (<i>skip to J4</i>)		2. Moderate pain		
		Pain less than daily		Times when pain is horrible or excruciating		
		2. Pain daily		Horrible of excrudiating		
3.	PAIN SITE	(If pain present, check all sites that apply in last 7 days)				
		Back pain	a.	Incisional pain	f.	
		Bone pain	b.	Joint pain (other than hip)	g.	
		Chest pain while doing usual		Soft tissue pain (e.g., lesion,		
		activities	C.	muscle)	h.	
		Headache	d.	Stomach pain	i.	
		Hip pain	e.	Other	j.	
4.	ACCIDENTS	(Check all that apply)				
		Fell in past 30 days	a.	Hip fracture in last 180 days	c.	
		Fell in past 31-180 days	b.	Other fracture in last 180 days	d.	
				NONE OF ABOVE	e.	
5.	STABILITY OF	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating)				
	CONDITIONS	Resident experiencing an acut chronic problem	e episo	de or a flare-up of a recurrent or	b.	
		End-stage disease, 6 or fewer	months	to live	c.	
		NONE OF ABOVE			d.	

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL	Chewing problem					a.
	PROBLEMS	Swallowing problem					b.
		Mouth pain					c.
		NONE OF ABOVE					d.
2.	HEIGHT AND WEIGHT	Record (a.) height in inches a recent measure in last 30 day standard facility practice—e.g. off, and in nightclothes	s; meás , in a.m.	ure we after vo	ight con	sistently in acc efore meal, wit	ord with
_		a. Weight loss—5 % or more		T (in.)	or 100	b. WT (lb.)	ot
3.	WEIGHT CHANGE	180 days 0. No 1. Yes		u uays	, OI 10 1	% OF MOTE III Id	ISI PER
		b.Weight gain—5 % or more		0 dave	or 10 º	6 or more in la	ct
		180 days	iii iast J	o uays	, 01 10 /	o or more in ia	31
		0. No 1. Yes	;				
4.	NUTRI- TIONAL	Complains about the taste of many foods	a.			or more of food ost meals	C.
	PROBLEMS	Regular or repetitive complaints of hunger	b.	NON	E OF AL	BOVE	d.
5.	NUTRI-	(Check all that apply in last 7 days)					
	NUTRI- TIONAL APPROACH-	Parenteral/IV	a.	Dietai		ement betweer	
	ES	Feeding tube	b.				f.
		Mechanically altered diet	c.	Plate utens		tabilized built-u	g.
		Syringe (oral feeding)	d.	Ona	planned	weight change	
		Therapeutic diet	e.	progra	am		h.
				NON	E OF AL	BOVE	i.
	PARENTERAL	(Skip to Section L if neither !	a nor 5	b is ch	ecked)		
	OR ENTERAL INTAKE	a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days 0. None 3. 51% to 75%					ıh
		1. 1% to 25% 2. 26% to 50%			to 100%	•	
		b. Code the average fluid inta					s
		0. None 1. 1 to 500 cc/day			to 1500 to 2000		

SECTION L. ORAL/DENTAL STATUS

1.	STATUS AND	Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	DISEASE PREVENTION	Has dentures or removable bridge	b.
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingiva); swollen or bleeding gums; oral abcesses; ulcers or rashes	e.
		Daily cleaning of teeth/dentures or daily mouth care—by resident or staff	f.
		NONE OF ABOVE	a

SEC	CTION M. SI	KIN CONDITION	
1.	ULCERS (Due to any cause)	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.]	Number at Stage
	oudooy	 Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. 	
		 b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. 	
		Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)	
		Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue	
		Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
3.	HISTORY OF RESOLVED	Resident had an ulcer that was resolved or cured in LAST 90 DAYS	
	ULCERS	0. No 1. Yes	
4.	OTHER SKIN	(Check all that apply during last 7 days)	
	PROBLEMS OR LESIONS	Abrasions, bruises	a.
	PRESENT	Burns (second or third degree)	b.
		Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	C.
		Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	d.
		Skin desensitized to pain or pressure	e.
		Skin tears or cuts (other than surgery)	f.
		Surgical wounds	g.
		NONE OF ABOVE	h.
5.	SKIN	(Check all that apply during last 7 days)	
	TREAT-	Pressure relieving device(s) for chair	a.
	MENTS	Pressure relieving device(s) for bed	b.
		Turning/repositioning program	c.
		Nutrition or hydration intervention to manage skin problems	d.
		Ulcer care	e.
		Surgical wound care	f.
		Application of dressings (with or without topical medications) other than to feet	
		Application of ointments/medications (other than to feet)	h.
		Other preventative or protective skin care (other than to feet)	i.
		NONE OF ABOVE	j.
6.	FOOT	(Check all that apply during last 7 days)	
	PROBLEMS AND CARE	Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems	a.
		Infection of the foot—e.g., cellulitis, purulent drainage	b.
		Open lesions on the foot	C.
		Nails/calluses trimmed during last 90 days	d.
		Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)	e.
		Application of dressings (with or without topical medications)	f.
		NONE OF ABOVE	
		<u> </u>	g.

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	AWAKE	Resident awake all or most of time (i.e., naps no more than one hour						
		per time period) in the: Morning	a.	Evening	c.			
		Afternoon	b.	NONE OF ABOVE	d.			
(If r	(If resident is comatose, skip to Section O)							
2.	AVERAGE TIME	(When awake and not	receivi	ng treatments or ADL care)				
		0. Most—more than 2/3 1. Some—from 1/3 to 2						
3.	PREFERRED		which a	ctivities are preferred)				
	ACTIVITY	Own room	a.	Outoide facility				
	SETTINGS	Day/activity room	b.	Outside facility	d.			
		Inside NH/off unit	c.	NONE OF ABOVE	e.			
4.	GENERAL		VCES w	hether or not activity is currently				
	ACTIVITY	available to resident)		Trips/shopping	g.			
	PREFER- ENCES	Cards/other games	a.	Walking/wheeling outdoors	h.			
	(adapted to	Crafts/arts	b.	Watching TV				
	resident's	Exercise/sports	c.	Ŭ	l.			
	current abilities)	Music	d.	Gardening or plants	j.			
	abilities)	Reading/writing	e.	Talking or conversing	k.			
		Spiritual/religious		Helping others	I.			
		activities	f.	NONE OF ABOVE	m.			

5.	i. PREFERS Code for resident preferences in daily routines CHANGE IN 0. No change 1. Slight change 2. Major change						
	DAILY ROUTINE a. Type of activities in which resident is currently involved						
		b. Extent of resident involvement in activities					
SECTION O MEDICATIONS							

CLC						
1.	NUMBER OF MEDICA- TIONS	Record the number of different medications used in the last 7 days; enter "0" if none used)				
2.	NEW MEDICA- TIONS	Resident currently receiving medications that were initiated during the last 90 days) No 1.Yes				
3.	INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)				
	DAYS RECEIVED THE FOLLOWING MEDICATION					

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL TREAT- MENTS.	a. SPECIAL CARE—Check to the last 14 days	eatmen	ts or programs receiv	ed during	
١.	PROCE-	TREATMENTS		Ventilator or respira	tor	l.
	DURES, AND PROGRAMS	Chemotherapy	a.	PROGRAMS		1.
		Dialysis	b.	Alcohol/drug treatm	ent	
		IV medication	c.	program		m.
		Intake/output	d.	Alzheimer's/demen	tia special	
		Monitoring acute medical condition	e.	care unit Hospice care		n. o.
		Ostomy care	f.	Pediatric unit		p.
		Oxygen therapy	g.	Respite care		q.
		Radiation	h.	Training in skills req return to the comm		
		Suctioning	i.	taking medications,	house	r.
		Tracheostomy care	j.	work, shopping, trar ADLs)	nsportation	١,
		Transfusions	k.	NONE OF ABOVE		s.
		following therapies was ac the last 7 calendar days [Note—count only post a	b.THERAPIES - Record the number of days and total minutes each following therapies was administered (for at least 15 minutes a dathe last 7 calendar days (Enter 0 if none or less than 15 min. dail [Note—count only post admission therapies] (A) = # of days administered for 15 minutes or more DAYS MIN			
		(B) = total # of minutes pro			(A)	(B)
		 a. Speech - language patholo 	gy and	audiology services		
		b.Occupational therapy				
		c. Physical therapy				
		d. Respiratory therapy				
		e. Psychological therapy (by a health professional)	any licei	nsed mental		
2.	INTERVEN- TION	(Check all interventions or s matter where received)	trategie	es used in last 7 day	r s —no	
	PROGRAMS	Special behavior symptom eva	aluation	program		a.
	FOR MOOD, BEHAVIOR,	Evaluation by a licensed menta	al health	n specialist in last 90	days	
	COGNITIVE	Group therapy				b. c.
	2000	Resident-specific deliberate ch mood/behavior patterns—e.g.				
		Reorientation—e.g., cueing	•		ū	e.
		NONE OF ABOVE				f.
3. I						n or for
- 1	ATIVE CARE	a. Range of motion (passive)		f. Walking		
		b. Range of motion (active)		g. Dressing or groor	ming	
		c. Splint or brace assistance		h. Eating or swallow	-	
		TRAINING AND SKILL PRACTICE IN:		i. Amputation/prost	•	
		d. Bed mobility		j Communication		
		e. Transfer		k. Other		

4.	DEVICES	(Use the following codes for last 7 days:)				
	AND	Ò. Not used				
	RESTRAINTS	Used less than daily Used daily				
		2. Osed daily Bed rails				
		264 14.10				
		a. — Full bed rails on all open sides of bed				
ı		b. — Other types of side rails used (e.g., half rail, one side)				
		c. Trunk restraint				
		d. Limb restraint				
		e. Chair prevents rising				
5.	HOSPITAL	Record number of times resident was admitted to hospital with an				
	STAY(S)	overnight stay in last 90 days (or since last assessment if less than 90				
		days). (Enter 0 if no hospital admissions)				
6.		Record number of times resident visited ER without an overnight stay				
	ROOM (ER) VISIT(S)	in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no ER visits)				
	. ,					
7.	PHYSICIAN	In the LAST 14 DAYS (or since admission if less than 14 days in				
	VISITS	facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 0 if none)				
_						
8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or				
	OKDEKS	practitioner) changed the resident's orders? Do not include order				
		renewals without change. (Enter 0 if none)				
9.		Has the resident had any abnormal lab values during the last 90 days				
	LAB VALUES	(or since admission)?				
		0. No 1. Yes				
		1				

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community				
		0. No	1. Yes			
		b. Resident has a suppo	ort person who is positive towards discharge			
		0. No	1. Yes			
		c. Stay projected to be of a short duration—discharge projected within 90 days (do not include expected discharge due to death)				
			Within 31-90 days Discharge status uncertain			
2.	OVERALL CHANGE IN	compared to status of 90	ufficiency has changed significantly as O days ago (or since last assessment if less			
	CARE NEEDS	0. No change 1. Improve suppor	red—receives fewer 2. Deteriorated—receives rts, needs less more support ive level of care	3		

SECTION R. ASSESSMENT INFORMATION 1. PARTICIPA- a. Resident: 0. No 1. Yes

	ASSESS-	b. Family:	0. No	1. Yes	No family	
	MENT	c. Significant other:	0. No	1. Yes	2. None	
2.	SIGNATURE	OF PERSON COO	RDINATING	GTHE ASSESS	SMENT:	
a. S	ignature of RN /	Assessment Coordi	nator (sign o	on above line)		
b. D	ate RN Assess	ment Coordinator				7
si	gned as comple	ete				
			Month	Day	Year	

	es		

Numeric Identifier		
Numeric identiller		

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1.	SPECIAL TREAT- MENTS AND	a. RECREATIONTHERAPY—Enter number of days and total minutes of recreation therapy administered (for at least 15 minutes a day) in the last 7 days (Enter 0 if none) DAYS MIN							
	PROCE- DURES	(A) (B)							
		(A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days							
		Skip unless this is a Medicare 5 day or Medicare readmission/ return assessment.							
	b. ORDERED THERAPIES—Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physica								
		therapy, occupational therapy, or speech pathology service? 0. No 1. Yes							
		If not ordered, skip to item 2							
		Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.							
		d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?							
2.	WALKING WHEN MOST SELF	Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:							
	SUFFICIENT	Resident received physical therapy involving gait training (P.1.b.c) Physical therapy was ordered for the resident involving gait training (T.1.b)							
		Resident received nursing rehabilitation for walking (P.3.f) Physical therapy involving walking has been discontinued within the past 180 days							
		Skip to item 3 if resident did not walk in last 7 days							
		(FOR FOLLOWING FIVE ITEMS, BASE CODING ONTHE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)							
		a. Furthest distance walked without sitting down during this episode.							
		0. 150+ feet 3. 10-25 feet 1. 51-149 feet 4. Less than 10 feet 2. 26-50 feet							
		b. Time walked without sitting down during this episode.							
		0. 1-2 minutes 3. 11-15 minutes 1. 3-4 minutes 4. 16-30 minutes 2. 5-10 minutes 5. 31+ minutes							
		c. Self-Performance in walking during this episode.							
		O. INDEPENDENT—No help or oversight SUPERVISION—Oversight, encouragement or cueing provided LIMITED ASSISTANCE—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance EXTENSIVE ASSISTANCE—Resident received weight bearing assistance while walking d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).							
		No setup or physical help from staff Setup help only One person physical assist							
		3. Two+ persons physical assist e. Parallel bars used by resident in association with this episode.							
		0. No 1. Yes							
3.	CASE MIX GROUP	Medicare State							
			_						

Numeric Identifier SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY Resident's Name: Medical Record No.: 1. Check if RAP is triggered. 2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status. · Describe: — Nature of the condition (may include presence or lack of objective data and subjective complaints). — Complications and risk factors that affect your decision to proceed to care planning. — Factors that must be considered in developing individualized care plan interventions. — Need for referrals/further evaluation by appropriate health professionals. Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident. Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.). 3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found. 4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs). (b) Care Planning Decision—check (a) Check if Location and Date of if addressed in A. RAP PROBLEM AREA triggered **RAP Assessment Documentation** care plan 1. DELIRIUM 2. COGNITIVE LOSS 3. VISUAL FUNCTION 4. COMMUNICATION 5. ADL FUNCTIONAL **REHABILITATION POTENTIAL** 6. URINARY INCONTINENCE AND **INDWELLING CATHETER** 7. PSYCHOSOCIAL WELL-BEING 8. MOOD STATE 9. BEHAVIORAL SYMPTOMS 10. ACTIVITIES 11. FALLS 12. NUTRITIONAL STATUS 13. FEEDING TUBES 14. DEHYDRATION/FLUID MAINTENANCE 15. DENTAL CARE 16. PRESSURE ULCERS 17. PSYCHOTROPIC DRUG USE 18. PHYSICAL RESTRAINTS 1. Signature of RN Coordinator for RAP Assessment Process 2. Month Day Year

3. Signature of Person Completing Care Planning Decision

ME	OS QUART	ΓERLY	ASS	ESSME	NT F	ORM				
A1.	RESIDENT NAME									
40	DOOM	a. (First)	b. (Mic	ddle Initia	l)	c.(Las	t)	d. (J	r/Sr)
A2.	ROOM NUMBER									
АЗ.	ASSESS- MENT REFERENCE DATE		Month	S observati		,	/ear			
\4a	DATE OF		. ,	corrected co	.,				′	lin
ч	REENTRY	last 90 d		since last a			dmission			
A6.	MEDICAL RECORD NO.		IOTIUT	Day		TE	al			
B1.	COMATOSE		nt veget	ative state/n						
B2.	MEMORY	0. No (<i>Recall o</i>	f what wa	1.Ye as learned o		` '	Section G	')		
		0. Men b. Long-t	nory OK	mory OK—	lemory p	roblem opears to			ıtes	
B4.	COGNITIVE SKILLS FOR	(regarding ta		, ,				
	DAILY DECISION- MAKING	1. MODI only 2. MODE	FIED INI ERATEL	IT—decisio DEPENDEI / IMPAIREI	V <i>CE</i> —so	me diffic	ulty in new			
			RELY IIV	IPAIRED—I						
B5.	INDICATORS OF DELIRIUM— PERIODIC DISOR-	requires of reside 0. Behav	conversent's bel		h staff ai this time	nd family e].				edge
	DERED THINKING/ AWARENESS	2. Behav function	rior prese ning (e.c	ent, not of re ent, over las g., new onse RACTED—(t 7 days a et or wors	appears o ening)			ent's us	sual
		sidetra	acked)				J		\	
		SURF	ROUNDI	ALTERED NGS—(e.g. es he/she is	, moves I	ips or tall	ks to some	one not		
		incohe subjec	erent, no ct; loses t	F DISORG/ nsensical, in rain of thou	relevant, ght)	or rambl	ing from si	ubject to		
		clothir mover	ng, napki ments or	RESTLESS ns, etc; freq calling out)	uent posi	tion char	iges; repet	itive phy	sical	
				LETHARG se; little bod			ness; stari	ng into s	space;	
		DAY— somet	-(e.g., sc imes pre	CTION VAF	etter, som times not	ietimes w :)	orse; beha			
C4.	MAKING SELF UNDER-	0. UNDE	•	mation cont D	ent—nov	vever abi	<i>e</i>)			
	STOOD	thoug	hts ETIMES	DERSTOOL UNDERST				`	-	
C6.	ABILITYTO	3. RARE	LY/NEV	ER UNDER erbal inforn			owever abi	(e)		
	UNDER- STAND	0. UNDE	RSTAN					,		
	OTHERS	messa 2. S <i>OME</i> direct of	ige E <i>TIMES</i> commun	UNDERST	A <i>NDS</i> —r	esponds	·		ple,	
E1.	INDICATORS	(Cada se	or indica	tors obser			s, irrespe	ctive of	the	
	OF DEPRES- SION, ANXIETY,	Indica Indica	tor not e tor of this	xhibited in la s type exhib s type exhib	ited up to	five day		7 days a	week)	
	SAD MOOD	VERBAL OF DIST		SSIONS		e.g.,	etitive verb calling out d help me'	for help,		
		statem	nents-e	e negative .g., " <i>Nothin</i>	9	d. Persi	stent ange	r with se		
		matter dead; Regre	rs; Would What's th	l rather be ne use; g lived so		ange	rs—e.g., e er at placer ng home; ved	nent in	-	
		b. Repeti	itive que: e do I go	stions—e.g. <i>;What do I</i>	,		deprecatio ing; I am o			

E1.	INDICATORS OF	VERBAL EXPRESSIONS OF DISTRESS SLEEP-CYCLE ISSUES j. Unpleasant mood in morning	
	DEPRES- SION,	f. Expressions of what k. Insomnia/change in usual	
	ANXIETY, SAD MOOD (cont.)	appear to be unrealistic fears—e.g., fear of being abandoned, left alone,	
	(CORL)	being with others APPEARANCE	
		g. Recurrent statements that something terrible is about to hannen—e a helieves brows	
		to happen—e.g., believes he or she is about to die, have a heart attack m. Crying, tearfulness	
		h. Repetitive health n. Repetitive health n. Repetitive physical movements—e.g., pacing,	
		complaints—e.g., persistently seeks medical hand wringing, restlessness, fidgeting, picking	
		concern with body LOSS OF INTEREST	
		functions o. Withdrawal from activities of interest—e.g., no interest in	
		complaints/concerns (non-health related) e.g., long standing activities or being with family/friends	
		persistently seeks attention/ reassurance regarding	
		schedules, meals, laundry, clothing, relationship issues	
E2.	MOOD PERSIS-	One or more indicators of depressed, sad or anxious mood were not easily aftered by attempts to "cheer up", console, or reassure	
	TENCE	the resident over last 7 days 0. No mood 1. Indicators present, 2. Indicators present, indicators easily altered not easily altered	
E4.	BEHAVIORAL	(A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days	
	SYMPTOMS	Behavior of this type occurred 1 to 3 days in last 7 days Behavior of this type occurred 4 to 6 days, but less than daily	
		Behavior of this type occurred daily	
		(B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered (A)	(B)
		Behavior was not easily altered A. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	T
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others	
		were threatened, screamed at, cursed at) c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others	+
		were hit, shoved, scratched, sexually abused)	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public,	
		smeared/threw food/feces, hoarding, rummaged through others' belongings)	
		RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	
G1.		F-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALI uring last 7 days—Not including setup)	
	0. INDEPEN	IDENT—No help or oversight —OR— Help/oversight provided only 1 or	2 times
	during last	SION—Oversight, encouragement or cueing provided 3 or more times d	uring
	1 or 2 time	—OR— Supervision (3 or more times) plus physical assistance provide is during last 7 days	
	guided ma	ASSISTANCE—Resident highly involved in activity; received physical hel ineuvering of limbs or other nonweight bearing assistance 3 or more time e help provided only 1 or 2 times during last 7 days	
	3. EXTENSI	VE ASSISTANCE—While resident performed part of activity, over last 7-	day
		lp of following type(s) provided 3 or more times: bearing support ff performance during part (but not all) of last 7 days	
		FPENDENCE—Full staff performance of activity during entire 7 days	
<u>_</u>	8. ACTIVITY	/ DID NOT OCCUR during entire 7 days How resident moves to and from lying position, turns side to side, and	(A)
a.	MOBILITY	positions body while in bed	
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	
C.	WALK IN ROOM	How resident walks between locations in his/her room.	
d.	WALK IN CORRIDOR	How resident walks in corridor on unit.	
e.	LOCOMO- TION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	
f.	LOCOMO-	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one	
	TION OFF UNIT	set aside to unling, activities, or treatments). In acting has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of	
		nourishment by other means (e.g., tube feeding, total parenteral nutrition).	

i.	TOILET USE	How resident uses the toilet ro transfer on/off toilet, cleanses, catheter, adjusts clothes				
j.	PERSONAL HYGIENE	How resident maintains persor brushing teeth, shaving, applyi and perineum (EXCLUDE bat	ng mak	eup, washing/drying		,
G2.	BATHING	How resident takes full-body b transfers in/out of tub/shower (Code for most dependent in	EXCLU	DE washing of back		
		[` '	A) BATHING SELF PERFORMANCE codes appear below			(A)
		Independent—No help pro Supervision Oversight b				
		 Supervision—Oversight h Physical help limited to tra 				
		Physical help in part of bar		•		
		4. Total dependence	Ū	•		
		8. Activity itself did not occur	during	entire 7 days		
G4.	FUNCTIONAL LIMITATION	(Code for limitations during las		s that interfered with	daily functio	ns or
	IN RANGE OF		y)	(B) VOLUNTARY	MOVEMEN	т
	MOTION	No limitation Limitation on one side		No loss Partial loss		
		Limitation on both sides		2. Full loss	((A) (B)
		a. Neck	olbow		_	
		b. Arm—Including shoulder or c. Hand—Including wrist or fine			-	
		d. Leg—Including hip or knee	gors		-	
		e. Foot—Including ankle or toe	es			
		f. Other limitation or loss				
G6.	MODES OF	(Check all that apply during l	ast 7 da	iys)		
	TRANSFER	Bedfast all or most of time	a.	NONE OF ABOVE		f.
		Bed rails used for bed mobility or transfer	h			
H1.	CONTINENCE	SELF-CONTROL CATEGOR	IFS			
		ident's PERFORMANCE OVE		SHIFTS)		
		IT—Complete control [includes does not leak urine or stool]	use of i	ndwelling urinary cat	heter or osto	omy
		CONTINENT—BLADDER, incost than weekly	ntinent	episodes once a wee	ek or less;	
	2. OCCASION	IALLY INCONTINENT—BLADI	DER, 2	or more times a wee	k but not da	ily;
	BOWEL, on		'D tand	ad to be incontinent.	daile but age	
	control pres	<i>TLY INCONTINENT</i> —BLADDE ent (e.g., on day shift); BOWEL,	2-3 tim	es a week	ually, but 50i	ne
	4. INCONTINE BOWEL, all	ENT—Had inadequate control E (or almost all) of the time	BLADDE	ER, multiple daily epi	sodes;	
a.	BOWEL CONTI- NENCE	Control of bowel movement, w programs, if employed	ith appl	iance or bowel contir	nence	
b.	BLADDER CONTI- NENCE	Control of urinary bladder functions soak through underpants), with programs, if employed	tion (if o	Iribbles, volume insui nces (e.g., foley) or c	fficient to continence	
H2.	BOWEL ELIMINATION PATTERN	Fecal impaction	d.	NONE OF ABOVE		e.
H3.	APPLIANCES	Any scheduled toileting plan	a.	Indwelling catheter		d.
	AND PROGRAMS	Bladder retraining program	b.	Ostomy present		
		External (condom) catheter	D.	NONE OF ABOVE		i.
12	INFECTIONS	, ,	C.	NONE OF ABOVE		j.
12.	INFECTIONS	30 dáys	j.			m.
13.	OTHER CURRENT	(Include only those diseases relationship to current ADL s				
	DIAGNOSES	medical treatments, nursing m	onitórin	g, or risk of death)		,
	AND ICD-9 CODES					
		a			<u> </u>	
J1.	PROBLEM	b. (Check all problems present	t in last	7 days)		
J1.	CONDITIONS	1,		Hallucinations		i.
		input	c.	NONE OF ABOVE		p.
J2.	PAIN	(Code the highest level of pa	in prese			
	SYMPTOMS	a. FREQUENCY with which		b. INTENSITY of pa	ain	
		resident complains or shows evidence of pain		1. Mild pain		
		0. No pain (skip to J4)		2. Moderate pain		
		1. Pain less than daily		3. Times when pain or excrutiating	is horrible	
L		2. Pain daily		or excrutialing		
J4.	ACCIDENTS	(Check all that apply)		Hip fracture in last	180 days	c.
		Fell in past 30 days	a.	Other fracture in las	-	d.
		Fell in past 31-180 days	b.	NONE OF ABOVE		e.

J5.	STABILITY		
	OF CONDITIONS	status unstable—(fluctuating, precarious, or deteriorating) Resident experiencing an acute episode or a flare-up of a recurrent or	a.
		chronic problem	b.
		End-stage disease, 6 or fewer months to live	c.
100		NONE OF ABOVE	d.
K3.	WEIGHT CHANGE	a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days	
		0. No 1. Yes	
		b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days	
		0. No 1. Yes	
K5.	NUTRI- TIONAL	Feeding tube	b.
	APPROACH-	On a planned weight change program NONE OF ABOVE	h.
N44	ES	(Record the number of ulcers at each ulcer stage—regardless of	i. ⊾o
M1.	(Due to any cause)	cause. If none present at a stage, record "0" (zero). Code all that apply	Number at Stage
	ouuco,	Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
M2.	TYPE OF	(For each type of ulcer, code for the highest stage in the last 7 days	using
	ULCER	scale in item M1—i.e., 0=none; stages 1, 2, 3, 4) a. Pressure ulcer—any lesion caused by pressure resulting in damage	
		of underlying tissue	
		 b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities 	
N1.	TIME AWAKE	(Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour	
		per time period) in the: Morning Evening	c.
		Afternoon b. NONE OF ABOVE	d.
(If r	esident is co	omatose, skip to Section O)	
N2.	AVERAGE	(When awake and not receiving treatments or ADL care)	
		0. Most—more than 2/3 of time 2. Little—less than 1/3 of time	
01	NUMBER OF		
	MEDICA- TIONS	enter "0" if none used)	
O4.	DAYS RECEIVED	(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)	
	THE	a. Antipsychotic d. Hypnotic	
	MEDICATION	e. Diuretic	
D.	DEVICES	c. Antidepressant Use the following codes for last 7 days:	
P4.	DEVICES AND	0. Not used	
	RESTRAINTS	5 1. Used less than daily	
1		2. Used daily Red rails	
		Bed rails	
		Bed rails a. — Full bed rails on all open sides of bed	
		Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint	
		Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising	
Q2.	OVERALL CHANGE IN	Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less	
Q2.	CHANGE IN	Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less 5 than 90 days) 0. No change 1. Improved—receives fewer 2. Deteriorated—receives	
Q2.	CHANGE IN	Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days)	
	CHANGE IN CARE NEEDS	Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer 2. Deteriorated—receives supports, needs less more support	
R2.	CHANGE IN CARE NEEDS SIGNATURE	Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less stan 90 days) 0. No change 1. Improved—receives fewer supports, needs less more support restrictive level of care EOF PERSON COORDINATING THE ASSESSMENT:	
R2.	CHANGE IN CARE NEEDS SIGNATURE	Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less stan 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care E OF PERSON COORDINATING THE ASSESSMENT:	
R2. a. Si b. D	CHANGE IN CARE NEEDS SIGNATURE	Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less stan 90 days) 0. No change 1. Improved—receives fewer 2. Deteriorated—receives supports, needs less more support restrictive level of care E OF PERSON COORDINATING THE ASSESSMENT:	
R2. a. Si b. D	CHANGE IN CARE NEEDS SIGNATURE ignature of RN all late RN Assess	Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less stan 90 days) 0. No change 1. Improved—receives fewer 2. Deteriorated—receives supports, needs less more support restrictive level of care E OF PERSON COORDINATING THE ASSESSMENT:	
R2. a. Si b. D	CHANGE IN CARE NEEDS SIGNATURE ignature of RN all late RN Assess	Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less stan 90 days) 0. No change 1. Improved—receives fewer 2. Deteriorated—receives supports, needs less more support restrictive level of care E OF PERSON COORDINATING THE ASSESSMENT: Assessment Coordinator (sign on above line)	
R2. a. Si b. D	CHANGE IN CARE NEEDS SIGNATURE ignature of RN all late RN Assess	Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less stan 90 days) 0. No change 1. Improved—receives fewer 2. Deteriorated—receives supports, needs less more support restrictive level of care E OF PERSON COORDINATING THE ASSESSMENT: Assessment Coordinator (sign on above line)	

MDS QUARTERLY ASSESSMENT FORM (OPTIONAL VERSION FOR RUG-III)

A1.	RESIDENT	IONAL VERSION FOR ROG-III)	—
ļ	NAME		_
A2.	ROOM	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr	r)
AZ.	NUMBER		
А3.	ASSESS- MENT	a. Last day of MDS observation period	
	REFERENCE DATE		
	DAIL	Month Day Year	
		b. Original (0) or corrected copy of form (enter number of correction)	
A4.	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 day	
			,-
		Month Day Year	
A6.	MEDICAL RECORD NO.		
B1.	COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (Skip to Section G)	
B2.		(Recall of what was learned or known)	
		a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem	
		b. Long-term memory OK—seems/appears to recall long past	
B3.	MEMORY/	0. Memory OK 1. Memory problem (Check all that resident was normally able to recall during	
50.	RECALL ABILITY	last 7 days)	
	ADILIT	Current season Location of own room b. That he/she is in a nursing home d.	
		Staff names/faces c. NONE OF ABOVE are recalled e.	
B4.	COGNITIVE SKILLS FOR	(Made decisions regarding tasks of daily life)	
	DAILY DECISION-	INDEPENDENT—decisions consistent/reasonable MODIFIED INDEPENDENCE—some difficulty in new situations	
	MAKING	only	
		2. MODERATELY IMPAIRED—decisions poor; cues/supervision required	
B5	INDICATORS	3. SEVERELY IMPAIRED—never/rarely made decisions (Code for behavior in the last 7 days.) [Note: Accurate assessment	
D 3.	OF DELIRIUM—	requires conversations with staff and family who have direct knowledge of resident's behavior over this time].	је
	PERIODIC	Behavior not present	
	DISOR- DERED	 Behavior present, not of recent onset Behavior present, over last 7 days appears different from resident's usual 	ı
	THINKING/ AWARENESS	functioning (e.g., new onset or worsening)	
		a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)	
		b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not	
		present; believes he/she is somewhere else; confuses night and day)	
		c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is	
		incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)	
		d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical	
		movements or calling out) e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)	
		f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE	
		DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)	
C4.	MAKING	(Expressing information content—however able)	
	SELF UNDER-	UNDERSTOOD USUALLY UNDERSTOOD—difficulty finding words or finishing	
	STOOD	thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete	
		requests 3. RARELY/NEVER UNDERSTOOD	
C6.	ABILITYTO	(Understanding verbal information content—however able)	
	UNDER- STAND	UNDERSTANDS USUALLY UNDERSTANDS—may miss some part/intent of	
	OTHERS	message	
		2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication.	
E1.	INDICATORS		
	OF DEPRES-	assumed cause) 0. Indicator not exhibited in last 30 days	
	SION, ANXIETY,	Indicator of this type exhibited up to five days a week Indicator of this type exhibited daily or almost daily (6, 7 days a week)	
	SAD MOOD	The state of the s	

	Numeric Ident	ifier			
E1.	INDICATORS OF	VERBAL EXPRESSIONS OF DISTRESS	h. Repetitive health complaints—e.g.,		
	DEPRES- SION, ANXIETY,	a. Resident made negative statements—e.g., "Nothing	persistently seeks medical attention, obsessive concern with body functions	n	
	SAD MOOD	matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die"	i. Repetitive anxious complaints/concerns (non- health related) e.g.,		
		b. Repetitive questions—e.g., "Where do I go; What do I do?"	persistently seeks attention/ reassurance regarding schedules, meals, laundry,		
		c. Repetitive verbalizations—	clothing, relationship issues SLEEP-CYCLE ISSUES		
		e.g., calling out for help, ("God help me")	j. Unpleasant mood in mornin	g	
		d. Persistent anger with self or others—e.g., easily annoyed, anger at	k. Insomnia/change in usual sleep pattern SAD, APATHETIC, ANXIOUS		
		placement in nursing home; anger at care received	APPEARANCE I. Sad, pained, worried facial		
		e. Self deprecation—e.g., "I am nothing; I am of no use to anyone"	expressions—e.g., furrowed brows m. Crying, tearfulness		
		f. Expressions of what appear to be unrealistic	n. Repetitive physical		
		fears—e.g., fear of being abandoned, left alone,	movements—e.g., pacing, hand wringing, restlessness fidgeting, picking	i,	
		being with others g. Recurrent statements that	LOSS OF INTEREST		
		something terrible is about to happen—e.g., believes	 Withdrawal from activities of interest—e.g., no interest in 		
		he or she is about to die, have a heart attack	long standing activities or being with family/friends		
E2.	MOOD	One or more indicators of de	p. Reduced social interaction pressed, sad or anxious mood were		
L2.	PERSIS- TENCE		s to "cheer up", console, or reassure)	
		No mood 1. Indicators pro- indicators easily altered			
E4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequence on Behavior not exhibited in I			
		Behavior of this type occu Behavior of this type occu	rred 1 to 3 days in last 7 days rred 4 to 6 days, but less than daily		
		Behavior of this type occu Behavioral symptom alter	ability in last 7 days		
		Behavior not present OR Behavior was not easily a	behavior was easily altered (A	4)	(B)
		oblivious to needs or safety)		4	
		were threatened, screamed	AVIORAL SYMPTOMS (others at, cursed at) EHAVIORAL SYMPTOMS (others	_	
		were hit, shoved, scratched,			
		SYMPTOMS (made disrupti self-abusive acts, sexual bel	ive sounds, noisiness, screaming,		
		e. RESISTS CARE (resisted to assistance, or eating)	aking medications/ injections, ADL		
G1.		-PERFORMANCE—(<i>Code</i> for uring last 7 days—Not includin	resident's PERFORMANCE OVER A ng setup)	LL	
	during last	7 days	OR— Help/oversight provided only 1 o		
	last7 days		ent or cueing provided 3 or more times e times) plus physical assistance provid		
	guided ma		involved in activity; received physical h weight bearing assistance 3 or more tin during last 7 days		า -
	period, hel —Weight-	p of following type(s) provided 3 bearing support		7-day	1
	4. TOTAL DE	f performance during part (but r FPENDENCE—Full staff perforr FDID NOT OCCUR during entire	nance of activity during entire 7 days		
	(B) ADL SUPP OVER ALL	PORT PROVIDED—(Code for a SHIFTS during last 7 days; c	MOST SUPPORT PROVIDED	(A)	(B)
	· ·	ce classification) r physical help from staff		ERF	R
	 Setup help One persor 		ADL activity itself did not occur during entire 7 days	SELF-PERF	SUPPORT
a.	BED MOBILITY	How resident moves to and fro and positions body while in bed	m lying position, turns side to side,	寸	
b.	TRANSFER	How resident moves between wheelchair, standing position (I			
	I .	`			

G1.					(A)	(B)
c.	WALK IN ROOM	How resident walks between lo	cations	in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor	on unit			
e.	LOCOMO- TION	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair				
f.	ON UNIT LOCOMO- TION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair				
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis				
h.	EATING		low resident eats and drinks (regardless of skill). Includes intake of ourishment by other means (e.g., tube feeding, total parenteral			
i.	TOILET USE		ow resident uses the toilet room (or commode, bedpan, urinal); ansfer on/off toilet, cleanses, changes pad, manages ostomy or			
j.	PERSONAL HYGIENE	How resident maintains persor brushing teeth, shaving, applyi hands, and perineum (EXCLU	ng make DE bath	eup, washing/drying face, is and showers)		
G2.	BATHING	How resident takes full-body be transfers in/out of tub/shower (in Code for most dependent in (A) BATHING SELF PERFOR 0. Independent—No help pro	EXCLUI self-peri MANCE	DE washing of back and hair.) formance.		(A)
		Supervision—Oversight had 2. Physical help limited to train	elp only	hy.		
		Physical help in part of bat Total dependence		•		
		8. Activity itself did not occur		•		
G3.	TEST FOR BALANCE	(Code for ability during test in t		- '		
	(see training manual)	Maintained position as requ Unsteady, but able to rebala Partial physical support duri or stands (sits) but does not Not able to attempt test with Balance while standing	nce self ng test; follow d	without physical support irections for test		
		b. Balance while sitting—positi	on, trun	k control		
	FUNCTIONAL LIMITATION IN RANGE OF MOTION	placed residents at risk of injur (A) RANGE OF MOTION 0. No limitation 1. Limitation on one side 2. Limitation on both sides		Sthat interfered with daily funct. (B) VOLUNTARY MOVEMENT 0. No loss 1. Partial loss 2. Full loss		(B)
		a. Neck b. Arm—Including shoulder or c. Hand—Including wrist or fing d. Leg—Including hip or knee e. Foot—Including ankle or toe f. Other limitation or loss	gers			
G6.	MODES OF	(Check all that apply during la	ast 7 da	ys)		
	TRANSFER	Bedfast all or most of time Bed rails used for bed mobility	a.	NONE OF ABOVE	f.	
G7.	TASK SEGMENTA- TION	or transfer Some or all of ADL activities w days so that resident could pe 0. No 1. Yes	rform th			
H1.	CONTINENCE	E SELF-CONTROL CATEGOR	IES	SHIFTS)		\neg
	0. CONTINEN	IT—Complete control [includes does not leak urine or stool]		•	tomy	,
	1. USUALLY C	CONTINENT—BLADDER, incomes than weekly	ntinent e	episodes once a week or less;		
	· ·	IALLY INCONTINENT—BLADI	DER, 20	or more times a week but not d	aily;	
		TLY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL,			ome	
	BOWEL, all	ENT—Had inadequate control E (or almost all) of the time	BLADDE	R, multiple daily episodes;		
a.	BOWEL CONTI- NENCE	Control of bowel movement, w programs, if employed	ith appli	ance or bowel continence		
b.	BLADDER CONTI- NENCE	Control of urinary bladder functions soak through underpants), with programs, if employed				
H2.	BOWEL ELIMINATION PATTERN	Diarrhea Fecal impaction	c. d.	NONE OF ABOVE	e.	

uэ	ADDITANCE				
Н3.	APPLIANCES	Any scheduled toileting plan	a.	Indwelling catheter	d.
	PROGRAMS	Bladder retraining program	b.	Ostomy present	i.
		External (condom) catheter	C.	NONE OF ABOVE	i.
				current ADL status, cognitive state	
	od and benavior tive diagnoses)	status, medical treatments, nu	irsing mo	onitoring, or risk of death. (Do not	list
11.	DISEASES	(If none apply, CHECK the N	IONE O	F ABOVE box)	
		MUSCULOSKELETAL		Multiple sclerosis	w.
		Hip fracture	m.	Quadriplegia	z.
		NEUROLOGICAL		PSYCHIATRIC/MOOD	
		Aphasia	r.	Depression	ee.
		Cerebral palsy Cerebrovascular accident	s.	Manic depressive (bipolar disease)	ff.
		(stroke)	t.	OTHER	
		Hemiplegia/Hemiparesis	v.	NONE OF ABOVE	rr.
12.	INFECTIONS	(If none apply, CHECK the N	IONE O	F ABOVE box)	
		Antibiotic resistant infection		Septicemia	g.
		(e.g., Methicillin resistant staph)	a.	Sexually transmitted diseases	h.
		Clostridium difficile (c. diff.)	b.	Tuberculosis	i.
		Conjunctivitis	c.	Urinary tract infection in last 30 days	j.
		HIV infection	d.	Viral hepatitis	k.
		Pneumonia	e.	Wound infection	I.
		Respiratory infection	f.	NONE OF ABOVE	m.
13.	OTHER CURRENT			osed in the last 90 days that have ognitive status, mood or behavior	
	DIAGNOSES	medical treatments, nursing n			olalao,
	AND ICD-9 CODES				
	00220	a		•	
J1.	PROBLEM	b. (Check all problems presen	t in last	7 days unless other time frame is	
JI.	CONDITIONS	indicated)	- III I I I I I		
		INDICATORS OF FLUID		OTHER	
		STATUS		Delusions Edema	e.
		Weight gain or loss of 3 or more pounds within a 7 day		Fever	g. h.
		period	a.	Hallucinations	i.
		Inability to lie flat due to shortness of breath		Internal bleeding	j.
		Dehydrated; output exceeds	b.	Recurrent lung aspirations in	
		input	c.	last 90 days Shortness of breath	k.
		Insufficient fluid; did NOT		Unsteady gait	l. n.
		consume all/almost all liquids provided during last 3 days	d.	Vomiting	0.
		,		NONE OF ABOVE	p.
J2.	PAIN	(Code the highest level of pa	ain prese	ent in the last 7 days)	
	SYMPTOMS	a. FREQUENCY with which		b. INTENSITY of pain	
		resident complains or shows evidence of pain		1. Mild pain	
		0. No pain (<i>skip to J4</i>)		2. Moderate pain	
		1. Pain less than daily		Times when pain is horrible or excrutiating	
		2. Pain daily			
J4.	ACCIDENTS	(Check all that apply) Fell in past 30 days		Hip fracture in last 180 days	c.
		Fell in past 31-180 days	a. b.	Other fracture in last 180 days <i>NONE OF ABOVE</i>	d.
J5.	STABILITY		sident's c	cognitive, ADL, mood or behavior	e.
	OF CONDITIONS	status unstable—(fluctuating,	precario	us, or deteriorating)	a.
	OONDINONO	Resident experiencing an acu chronic problem	te episo	de or a flare-up of a recurrent or	b.
		End-stage disease, 6 or fewer	months	to live	c.
		NONE OF ABOVE			d.
K1.	ORAL	Chewing problem			a.
	PROBLEMS	Swallowing problem NONE OF ABOVE			b.
K2.	HEIGHT		and (b .)	weight in pounds. Base weight	d. on mosi
	AND	recent measure in last 30 day	/s ; meás	ure weight consistently in accord	with
	WEIGHT	off, and in nightclothes	., 111 a.II).	after voiding, before meal, with s	1062
				HT (in.) b. WT (lb.)	\perp
K3.	WEIGHT	_	in last 3	0 days; or 10 % or more in last	
	CHANGE	180 days 0. No 1. Yes	S		
			in last 3	0 days; or 10 % or more in last	
		180 days 0. No 1. Yes	2		
1	i	1.10	,		1

K5.	NUTRI-	(Check all	that apply	in last	7 days	5)	
	TIONAL APPROACH-	Parenteral/l	V		a.	On a planned weight change	
	ES	Feeding tub	е		b.	program NONE OF ABOVE	h. i.
M1.	ULCERS	(Record the	number of	ulcers a	at each u	ulcer stage—regardless of	1. F &
	(Due to any	cause. If no	ne present a	at a stag	ge, reco	rd "0" (zero). Code all that apply e.) [Requires full body exam.]	Number at Stage
	cause)	a. Stage 1.				edness (without a break in the ear when pressure is relieved.	
		b. Stage 2.				skin layers that presents lister, or shallow crater.	
		c. Stage 3.	A full thickn tissues - pre underminin	esents	as a dee	est, exposing the subcutaneous ep crater with or without ue.	
		d. Stage 4.		ess of s	skin and	subcutaneous tissue is lost,	
M2.	TYPE OF ULCER					nighest stage in the last 7 days e; stages 1, 2, 3, 4)	
			ulcer—any ying tissue	lesion	caused	by pressure resulting in damage	
		extremitie	es '			y poor circulation in the lower	
M4.	OTHER SKIN PROBLEMS	Ι'	that apply o	luring la	ast 7 da	ys)	
	OR LESIONS	Abrasions, b		logroo)			a.
	PRESENT	,	ond or third o	• ,		s, cuts (e.g., cancer lesions)	b. c.
						rash, heat rash, herpes zoster	d.
		Skin desens	sitized to pai	n or pre	essure	•	e.
			r cuts (other	than s	urgery)		f.
		Surgical wo					g.
		NONE OF	ABOVE that apply (durina	lact 7 de	ave)	h.
M5.	SKIN TREAT-	`	lieving devi	•		ays)	
	MENTS		lieving devic	. ,			a. b.
			ositioning p	. ,			c.
		Ι .	٠.	•		anage skin problems	d.
		Ulcer care	•				e.
		Surgical wo	ound care				f.
		Application to feet	of dressings	s (with o	or withou	ut topical medications) other than	g.
					,	other than to feet)	h. :
		NONE OF		otectiv	e skin ca	are (other than to feet)	i. j.
M6.	FOOT		that apply	during	last 7 da	ays)	j.
10.	PROBLEMS	Resident ha	as one or mo	ore foot	problen	ns—e.g., corns, callouses,	
	AND CARE	bunions, ha	mmer toes,	overlap	ping to	es, pain, structural problems	a.
		l			ılitis, pur	rulent drainage	b.
			ns on the foo		l4 00 .	da	c.
			es trimmed			•	d.
			ls, toe separ		cuve ioc	ot care (e.g., used special shoes	е.
		Application	of dressings	s (with o	or withou	ut topical medications)	f.
		NONE OF	ABOVE				g.
N1.	TIME	(Check app	oropriate tir	ne per	iods ov	er last 7 days)	
	AWAKE	Resident av per time per		ost of t	,	, naps no more than one hour	
		Morning	' г	a.	Eveni	ing	c.
		Afternoon		b.		E OF ABOVE	d.
`	esident is co		•		•	tmente es ADL	
N2.	AVERAGE TIME	(wnen awa	ike and not	receiv	ing trea	tments or ADL care)	
	INVOLVED IN					2. Little—less than 1/3 of time	
01	ACTIVITIES NUMBER OF		rom 1/3 to 2/ e number o			3. None dications used in the last 7 days	
<u> </u>	MEDICA- TIONS	enter "0" if r					
О3.	INJECTIONS	the last 7 d	l ays ; enter "(" if nor	ne úsed)		
04.	DAYS RECEIVED THE	used. Note-	—enter "1" f	of DAYS or long	3 during acting r	l last 7 days ; enter "0" if not meds used less than weekly)	
	FOLLOWING	a. Antipsych				d. Hypnotic	
	MEDICATION	b. Antianxie c. Antidepre	•			e. Diuretic	

TREAT- MENTS, PROCE- DURES, AND PROGRAMS	the last 14 days TREATMENTS		Ventilator or respira	40.			
PROCE- DURES, AND	TREATMENTS		Ventilator or respira	40.0			
DURES, AND				lOI		I.	
	Chemotherapy	a.	PROGRAMS			ı.	
	Dialysis	b.	Alcohol/drug treatm	ent			
	IV medication		program	ion.		m.	
	Intake/output		Alzheimer's/demen	tia speci	ial		_
	·	u.	care unit			n.	
	condition	e.	Hospice care			0.	
	Ostomy care	f.					
	Oxygen therapy	g.				q.	
	Radiation	h.					
	Suctioning	i.	taking medications,	hoúse		r.	
	Tracheostomy care	i.		nsportat	ion,		
	Transfusions	k	· ′	•		•	
	the following therapies wa in the last 7 calendar day [Note—count only post a (A) = # of days administered	ns admin ys (Ente admiss d for 15	nistered (for at least er 0 if none or less th ion therapies] minutes or more	15 minu han 15 i	utes min. MI	a da dail N	ay)
	` '			()	Ť	Ĺ	
		.g, and	addictory solvides		+		\vdash
	b. Occupational therapy				_		
	c. Physical therapy						
	d. Respiratory therapy						
	e. Psychological therapy (by a health professional)	any lice	nsed mental				
NURSING	Record the NUMBER OF DA	YS eac	h of the following re	habilita	tion	or	
TION/	more than or equal to 15 m	inutes	per day in the last	reside 7 days	nt fo	or	
ATIVE CARE	a. Range of motion (passive)		f. Walking				
	b. Range of motion (active)		q. Dressing or groo	ming			
	c. Splint or brace assistance			•			
	TRAINING AND SKILL		· ·	•	aro.		
				11 10313 00	ai C		
	•		*				
DEVICES		ast 7 da					
AND	0. Not used	ust / ut	<i>1</i> 93.				
RESTRAINTS							
	Bed rails						
	a. — Full bed rails on all ope	n sides (of bed				
	b. — Other types of side rails	s used (e	e.g., half rail, one side	e)			
	c. Trunk restraint	,	,	,			_
	d. Limb restraint						
	e. Chair prevents rising						
PHYSICIAN VISITS	facility) how many days has th	e physic	ian (or authorized as		or		
PHYSICIAN	In the LAST 14 DAYS (or since	e admis	sion if less than 14 d	ays in			
ORDERS	facility) how many days has the practitioner) changed the residual	e physic lent's or	ian (or authorized as ders? <i>Do not include</i>	sistant c	or		
OVERALL				ificantly	as		
CHANGE IN	compared to status of 90 days						
CARE NEEDS	than 90 days) 0 No change 1 Improved—r	eceives	fewer 2 Deteriorate	d—rece	ives		
	supports, ne	eds less	more suppo				
SIGNATURE	OF PERSON COORDINATIN	GTHE /	ASSESSMENT:				
anature of DNI	Accecement Coordinator (aire	on ohor.	a lina)				
_		uri abuv		1 1	_		
b. Date RN Assessment Coordinator signed as complete Month Day Year							
	IVIOLIUI						
	TVIOLIU I						
	NURSING REHABILITA- TION RESTOR- ATIVE CARE DEVICES AND RESTRAINTS PHYSICIAN VISITS PHYSICIAN ORDERS OVERALL CHANGE IN CARE NEEDS SIGNATURE (gnature of RN /	Intake/output Monitoring acute medical condition Ostomy care Oxygen therapy Radiation Suctioning Tracheostomy care Transfusions b. THERAPIES - Record the the following therapies wain the last 7 calendar day [Note—count only post: (A) = # of days administerer (B) = total # of minutes pro a. Speech - language patholo b. Occupational therapy c. Physical therapy d. Respiratory therapy e. Psychological therapy (by health professional) NURSING REHABILITATION/ RESTOR- ATIVE CARE ATIVE CARE DEVICES AND RESTRAINTS I Used less than daily 2. Used daily Bed rails a. — Full bed rails on all ope b. — Other types of side rails c. Trunk restraint d. Limb restraint e. Chair prevents rising PHYSICIAN VISITS PHYSICIAN ORDERS PHYSICIAN ORDERS PHYSICIAN ORDERS Resident's overall level of self- compared to status of 90 days than 100 days) 0. No change 1. Improved—r supports, ne- restrictive lex-	Intake/output Monitoring acute medical condition Ostomy care Oxygen therapy Radiation Suctioning Tracheostomy care Transfusions b. THERAPIES - Record the number the following therapies was admining in the last 7 calendar days (Ente (Note—count only post admiss (A) = # of days administered for 15 (B) = total # of minutes provided in a. Speech - language pathology and b. Occupational therapy c. Physical therapy d. Respiratory therapy e. Psychological therapy (by any lice health professional) NURSING REHABILITATION RESTOR- ATIVE CARE NURSING REHABILITATION RESTOR- ATIVE CARE NURSING REHABILITATION RESTOR- ATIVE CARE DEVICES AND RESTOR- ATIVE CARE DEVICES AND RESTRAINTS Use the following codes for last 7 days (a label particular of the number o	Intake/output Monitoring acute medical condition Ostomy care Oxygen therapy Radiation Suctioning Tracheostomy care Interview of the following therapies was administered for at large in the last 7 calendar days (Enter 0 if none or less tin the last 7 calendar days (Enter 0 if none or less tin the last 7 calendar days (Enter 0 if none or less tin the last 7 calendar days (Enter 0 if none or less tin the last 7 calendar days (Enter 0 if none or less tin the last 7 calendar days (Enter 0 if none or less tin the last 7 calendar days (Enter 0 if none or less tin the last 7 calendar days (Enter 0 if none or less tin the last 7 calendar days (Enter 0 if none or less tin the last 7 calendar days (Enter 0 if none or less tin the last 7 calendar days (Enter 0 if none or less tin the last 7 days at doubting the days (Enter 0 if none or less tin the last 7 days are day in the last 8 days (Enter 0 if none or less than 15 min. daily.) NURSING REHABILITATION (Enter 0 if none than or equal to 15 minutes per day in the last (Enter 0 if none or less than 15 min. daily.) RESTOR. ATIVE CARE (Enter 0 if none or less than 15 min. daily.) B. Range of motion (passive) (a. Range of motion (passive) (b. Range of secondar days and total daily) (b. Range of motion (passive) (b. Range of secondar days details (b. Chier 0 if none) (b. Chance in compared to status of 90 days ago (or since last assessment Care Nature of RN Assessment Coordinator (sign on above line)	Intake/output Monitoring acute medical condition Ostomy care Oxygen therapy Radiation Nursing Record the number of days and total minutes the following therapies was administered (for at least 15 min in the last 7 calendar days (Enter 0 in none or less than 15 (A)) RESTOR- AITVE CARE NURSING RESTRAINTS RESTRAINTS DEVICES AND RESTRAINTS Losd daily Bed rails Alzheimer's/dementia spec care unit Alzheimer's/dementia spec care unit Respite care unit Respite care Poxygen therapy Redication, house Inability required to taking medications, house Inability and ADLs) ITransfusions NONE OF ABOVE b. THERRPIES - Record the number of days and total minutes the following therapies was administered (for at least 15 min in the last 7 calendar days (Enter 0 in none or less than 15 (Note—count only post admission therapies) (A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days (A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days (A) = Respiratory therapy d. Respiratory therapy d. Respiratory therapy e. Psychological therapy (by any licensed mental health professional) NURSING REHABILITA RECORD the NUMBER OF DAYS each of the following rehabilitate restorative techniques or practices was provided to the reside more than or equal to 15 minutes per day in the last 7 days (B) - Psychological therapy (by any licensed mental health professional) NURSING RESTRAINTS RESTOR- AITVE CARE Resident's over the standard the following rehabilitate restorative techniques or practices was provided to the resident's ordinary in the last 7 days. (A) - Psychological therapy (by any licensed mental health professional) NURSING RESTRAINTS B. Walking Record the NUMBER OF DAYS each of the following rehability restoration (passive) B. Range of motion (passive) B. Care in the last 7 days	Intake/output Monitoring acute medical condition Ostomy care Oxygen therapy Radiation Tacheostomy care Dxygen therapy Radiation Transfusions Intake/output Respite care Respite care Training in skills required to return to the community (e.g., taking medications, house the following therapies was administered (for at least 15 minutes in the last 7 calendar days (Enter 0 if none or less than 15 min. Note—count only post admission therapies) ADLS) Transfusions Intote—count only post admission therapies) APPLYSICIAN Respite care Training in skills required to return to the community (e.g., taking medications, house the following therapies was administered (for at least 15 minutes in the last 7 calendar days (Enter 0 if none or less than 15 min. INOte—count only post admission therapies) APPLYSICIAN Respite care Training in skills required to return to the community (e.g., taking medications, house the following therapies was administered (for at least 15 minutes in the last 7 days and total minutes or day in none or (B) = total # of minutes provided in at least 7 days BAYS MINURSING (A) = total # of minutes provided in last 7 days REHABILITA Respite care Respite care Training in skills required to form the minutes or day in the last 7 days (A) = total # of minutes provided in last 7 days REHABILITA Respite care Respite care Training in skills required to form the last 7 days (A) = total # of minutes provided in the last 7 days REHABILITA Respite care Respite care Training in skills required to form the last 7 days ADLS) Respite care Respite care Training in skills required to form the last 7 days Respite care Respite care Training in skills required to form the last 7 days ADLS) Respite care Training in skills required to form the last 7 days ADLS) Respite care Training in skills required to form the last 7 days Respite care Respite care Training in skills required to form the last 7 days ADLS) Respite care Respite care Training in skills required to form the	Intake/output Monitoring acute medical condition Ostomy care Oxygen therapy Radiation Respite care Oxygen therapy Radiation Respite care Oxygen therapy Radiation Respite care Respite care Pediatric unit Respite care Training in skills required to return to the community (e.g., taking medications, house with the following therapies was administered for at least 15 minutes as of in the last 7 calendar days (Enter 0 if none or less than 15 min. dall, Inote—count only post admission therapies) ADLS) Interespitation Interespitat

MDS QUARTERLY ASSESSMENT FORM (OPTIONAL VERSION FOR RUG-III 1997 Update)

	DECIDENT			
A1.	RESIDENT NAME			
		a. (First) b. (Mic	ddle Initial) c. (Last) d. (Jr/s	Sr)
A2.	ROOM NUMBER			
А3.	ASSESS-	Last day of MDS observation	on period	
	MENT REFERENCE			
	DATE	Month Day	/ Year	
		o. Original (0) or corrected co	py of form (enter number of correction)	
A4a.	DATE OF REENTRY		recent temporary discharge to a hospital inssessment or admission if less than 90 d	
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		•
A6.	MEDICAL	Month Day	Year	
Αυ.	RECORD NO.			
B1.	COMATOSE). No 1. Ye	(, , , , , , , , , , , , , , , , , , ,	
B2.	MEMORY	Recall of what was learned on Short-term memory OK—	seems/appears to recall after 5 minutes	
		0. Memory OK 1. M	lemory problem	
			seems/appears to recall long past lemory problem	
В3.	MEMORY/ RECALL	Check all that resident was last 7 days)	normally able to recall during	
	ABILITY	Current season a.	That he/she is in a nursing home	
		Location of own room b. Staff names/faces c.	NONE OF ABOVE are recalled e.	
B4.	COGNITIVE SKILLS FOR	Made decisions regarding ta	asks of daily life)	
	DAILY DECISION-	D. INDEPENDENT—decision	ns consistent/reasonable VCE—some difficulty in new situations	
	MAKING	only	O—decisions poor; cues/supervision	
		required 3. <i>SEVERELY IMPAIRED</i> —r	•	
B5.	INDICATORS	Code for behavior in the last	7 days.) [Note: Accurate assessment	_
	OF DELIRIUM—	equires conversations with of resident's behavior over	h staff and family who have direct knowled this time].	dge
	PERIODIC DISOR-	Behavior not present Behavior present, not of re	cent onset	
	DERED THINKING/		t 7 days appears different from resident's usu	ıal
	AWARENESS		, t o. 110.00g)	
			e.g., difficulty paying attention; gets	
		a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I	PERCEPTION OR AWARENESS OF	
		a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g.		
		a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g. present; believes he/she is day) c. EPISODES OF DISORGA incoherent, nonsensical, in	PERCEPTION OR AWARENESS OF , moves lips or talks to someone not somewhere else; confuses night and ANIZED SPEECH—(e.g., speech is relevant, or rambling from subject to	
		a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g. present; believes he/she is day) c. EPISODES OF DISORGA incoherent, nonsensical, ir subject; loses train of thoug	PERCEPTION OR AWARENESS OF , moves lips or talks to someone not somewhere else; confuses night and ANIZED SPEECH—(e.g., speech is relevant, or rambling from subject to	
		a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g. present; believes he/she is day) c. EPISODES OF DISORGA incoherent, nonsensical, ir subject; loses train of thou d. PERIODS OF RESTLESS clothing, napkins, etc; frequ movements or calling out)	PERCEPTION OR AWARENESS OF, moves lips or talks to someone not somewhere else; confuses night and ANIZED SPEECH—(e.g., speech is relevant, or rambling from subject to ght) SNESS—(e.g., fidgeting or picking at skin, uent position changes; repetitive physical	
		a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g. present; believes he/she is day) c. EPISODES OF DISORGA incoherent, nonsensical, ir subject; loses train of though d. PERIODS OF RESTLESS clothing, napkins, etc; freque movements or calling out) e. PERIODS OF LETHARG' difficult to arouse; little bod	PERCEPTION OR AWARENESS OF, moves lips or talks to someone not somewhere else; confuses night and ANIZED SPEECH—(e.g., speech is relevant, or rambling from subject to ght) SNESS—(e.g., fidgeting or picking at skin, uent position changes; repetitive physical Y—(e.g., sluggishness; staring into space; y movement)	
		a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g., present; believes he/she is day) c. EPISODES OF DISORGA incoherent, nonsensical, ir subject; loses train of thou d. PERIODS OF RESTLESS clothing, napkins, etc; frequ movements or calling out) e. PERIODS OF LETHARG' difficult to arouse; little bod f. MENTAL FUNCTION VAR DAY—(e.g., sometimes be	PERCEPTION OR AWARENESS OF, moves lips or talks to someone not somewhere else; confuses night and ANIZED SPEECH—(e.g., speech is relevant, or rambling from subject to ght) SNESS—(e.g., fidgeting or picking at skin, uent position changes; repetitive physical Y—(e.g., sluggishness; staring into space; y movement) RIES OVER THE COURSE OF THE etter, sometimes worse; behaviors	
C4.	MAKING	a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g. present; believes he/she is day) c. EPISODES OF DISORGA incoherent, nonsensical, ir subject; loses train of thoug d. PERIODS OF RESTLES clothing, napkins, etc; frequenovements or calling out) e. PERIODS OF LETHARG difficult to arouse; little bod f. MENTAL FUNCTION VAR	PERCEPTION OR AWARENESS OF, moves lips or talks to someone not somewhere else; confuses night and ANIZED SPEECH—(e.g., speech is relevant, or rambling from subject to ght) SNESS—(e.g., fidgeting or picking at skin, uent position changes; repetitive physical Y—(e.g., sluggishness; staring into space; y movement) RIES OVER THE COURSE OF THE stter, sometimes worse; behaviors times not)	
C4.	SELF UNDER-	a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g. present; believes he/she is day) c. EPISODES OF DISORGA incoherent, nonsensical, ir subject; loses train of thour d. PERIODS OF RESTLESS clothing, napkins, etc; freqi movements or calling out) e. PERIODS OF LETHARG' difficult to arouse; little bod f. MENTAL FUNCTION VAR DAY—(e.g., sometimes be sometimes present, some (Expressing information cont	PERCEPTION OR AWARENESS OF, moves lips or talks to someone not a somewhere else; confuses night and ANIZED SPEECH—(e.g., speech is relevant, or rambling from subject to ght) SNESS—(e.g., fidgeting or picking at skin, uent position changes; repetitive physical Y—(e.g., sluggishness; staring into space; y movement) RIES OVER THE COURSE OF THE etter, sometimes worse; behaviors times not) tent—however able)	
C4.	SELF	a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g., present; believes he/she is day) c. EPISODES OF DISORGA incoherent, nonsensical, ir subject; loses train of thou d. PERIODS OF RESTLESS clothing, napkins, etc; freque movements or calling out e. PERIODS OF LETHARGY difficult to arouse; little bod f. MENTAL FUNCTION VAR DAY—(e.g., sometimes be sometimes present, somet (Expressing information contect) UNDERSTOOD thoughts	PERCEPTION OR AWARENESS OF, moves lips or talks to someone not a somewhere else; confuses night and an	
C4.	SELF UNDER-	a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g. present; believes he/she is day) c. EPISODES OF DISORGA incoherent, nonsensical, ir subject; loses train of though d. PERIODS OF RESTLESS clothing, napkins, etc; frequency movements or calling out) e. PERIODS OF LETHARG difficult to arouse; little bod f. MENTAL FUNCTION VAR DAY—(e.g., sometimes be sometimes present, somet [Expressing information contouthoughts] c. SOMETIMES UNDERSTO requests	PERCEPTION OR AWARENESS OF, moves lips or talks to someone not a somewhere else; confuses night and ANIZED SPEECH—(e.g., speech is relevant, or rambling from subject to ght) SNESS—(e.g., fidgeting or picking at skin, uent position changes; repetitive physical Y—(e.g., sluggishness; staring into space; y movement) RIES OVER THE COURSE OF THE etter, sometimes worse; behaviors times not) tent—however able) D—difficulty finding words or finishing	
C4.	SELF UNDER- STOOD	a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g. present; believes he/she is day) c. EPISODES OF DISORGA incoherent, nonsensical, ir subject; loses train of thoug d. PERIODS OF RESTLESS clothing, napkins, etc; frequ movements or calling out) e. PERIODS OF LETHARG' difficult to arouse; little bod f. MENTAL FUNCTION VAR DAY—(e.g., sometimes be sometimes present, somet (Expressing information cont b. UNDERSTOOD 1. UNDERSTOOD 1. USUALLY UNDERSTO 1. EXPRESSING INTERSTORY 1. SOMETIMES UNDERSTO 1. TOTALLY UNDERSTO 1.	PERCEPTION OR AWARENESS OF, moves lips or talks to someone not a somewhere else; confuses night and ANIZED SPEECH—(e.g., speech is relevant, or rambling from subject to ght) SNESS—(e.g., fidgeting or picking at skin, uent position changes; repetitive physical Y—(e.g., sluggishness; staring into space; y movement) RIES OVER THE COURSE OF THE etter, sometimes worse; behaviors times not) tent—however able) D—difficulty finding words or finishing	
	SELF UNDER- STOOD ABILITYTO UNDER- STAND	a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g., present; believes he/she is day) c. EPISODES OF DISORGA incoherent, nonsensical, ir subject; loses train of thoug d. PERIODS OF RESTLESS clothing, napkins, etc; freque movements or calling out) e. PERIODS OF LETHARG' difficult to arouse; little bod f. MENTAL FUNCTION VAR DAY—(e.g., sometimes be sometimes present, somet (Expressing information conti- thoughts 2. SOMETIMES UNDERSTO trequests 3. RARELY/NEVER UNDER Understanding verbal information understanding verbal information. UNDERSTANDS	PERCEPTION OR AWARENESS OF, moves lips or talks to someone not a somewhere else; confuses night and an annual elevant, or rambling from subject to ght) SNESS—(e.g., fidgeting or picking at skin, uent position changes; repetitive physical and position changes; repetitive physical and position changes; staring into space; y movement) RIES OVER THE COURSE OF THE letter, sometimes worse; behaviors times not) The interpretation of the properties of the position of the position of the position of the properties of the position of the posit	
	SELF UNDER- STOOD ABILITYTO UNDER-	a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g., present; believes he/she is day) c. EPISODES OF DISORGA incoherent, nonsensical, ir subject; loses train of thoug d. PERIODS OF RESTLESS clothing, napkins, etc; frequent movements or calling out) e. PERIODS OF LETHARG' difficult to arouse; little bod f. MENTAL FUNCTION VAR DAY—(e.g., sometimes be sometimes present, somet (Expressing information conti- (Expressing information conti- thoughts 2. SOMETIMES UNDERSTO UNDERSTANDS 1. USUALLY UNDERSTAND message 2. SOMETIMES UNDERSTA	PERCEPTION OR AWARENESS OF, moves lips or talks to someone not a somewhere else; confuses night and an	
	SELF UNDER- STOOD ABILITYTO UNDER- STAND	a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g. present; believes he/she is day) c. EPISODES OF DISORGA incoherent, nonsensical, ir subject; loses train of thoug d. PERIODS OF RESTLESS clothing, napkins, etc; frequencements or calling out) e. PERIODS OF LETHARG difficult to arouse; little bod f. MENTAL FUNCTION VAR DAY—(e.g., sometimes be sometimes present, somet [Expressing information conti- toughts] c. SOMETIMES UNDERSTO UNDERSTANDS 1. USUALLY UNDERSTAND message 2. SOMETIMES UNDERSTAND message 2. SOMETIMES UNDERSTAND message 2. SOMETIMES UNDERSTAND direct communication 3. RARELY/NEVER UNDERSTANDE	PERCEPTION OR AWARENESS OF, moves lips or talks to someone not a somewhere else; confuses night and an	
C6.	SELF UNDER- STOOD ABILITYTO UNDER- STAND OTHERS INDICATORS OF	a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g. present; believes he/she is day) c. EPISODES OF DISORGA incoherent, nonsensical, ir subject; loses train of thoug d. PERIODS OF RESTLES clothing, napkins, etc; frequencements or calling out) e. PERIODS OF LETHARG difficult to arouse; little bod f. MENTAL FUNCTION VAR DAY—(e.g., sometimes be sometimes present, some (Expressing information contity) 1. UNDERSTOOD 1. USUALLY UNDERSTOOD 1. USUALLY UNDERSTOOD 1. USUALLY UNDERSTOOD 1. USUALLY UNDERSTOOD 1. UNDERSTANDS 1. USUALLY UNDERSTAND message 2. SOME TIMES UNDERSTA direct communication 3. RARELY/NEVER UNDERST Code for indicators observassum of the communication 3. RARELY/NEVER UNDERST Code for indicators observassumed cause)	PERCEPTION OR AWARENESS OF, moves lips or talks to someone not a somewhere else; confuses night and an	
C6.	SELF UNDER- STOOD ABILITYTO UNDER- STAND OTHERS INDICATORS	a. EASILY DISTRACTED—(sidetracked) b. PERIODS OF ALTERED I SURROUNDINGS—(e.g., present; believes he/she is day) c. EPISODES OF DISORGA incoherent, nonsensical, ir subject; loses train of thoug d. PERIODS OF RESTLESS clothing, napkins, etc; freque movements or calling out) e. PERIODS OF LETHARG' difficult to arouse; little bod f. MENTAL FUNCTION VAR DAY—(e.g., sometimes be sometimes present, somet [Expressing information cont to UNDERSTOOD 1. USUALLY UNDERSTO 2. SOMETIMES UNDERSTO Trequests 3. RARELY/NEVER UNDER Understanding verbal inform 1. UNDERSTANDS 1. USUALLY UNDERSTAND message 2. SOMETIMES UNDERSTA direct communication 3. RARELY/NEVER UNDER [Code for indicators observassumed cause) 1. Indicator not exhibited in la 1. Indicator of this type exhibited in la 1. Indicator	PERCEPTION OR AWARENESS OF, moves lips or talks to someone not a somewhere else; confuses night and an	

	Numeric Ident	tier	
E1.	INDICATORS OF DEPRES- SION, ANXIETY, SAD MOOD	a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die" b. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about	petitive health inplaints—e.g., sistently seeks medical antion, obsessive concern in body functions petitive anxious inplaints/concerns (non- alth related) e.g., sistently seeks attention/ ssurance regarding ledules, meals, laundry, thing, relationship issues EP-CYCLE ISSUES pleasant mood in morning omnia/change in usual ep pattern APATHETIC, ANXIOUS PEARANCE d, pained, worried facial oressions—e.g., furrowed ws lying, tearfulness petitive physical vements—e.g., pacing, d wringing, restlessness, jeting, picking S OF INTEREST chdrawal from activities of lerest—e.g., no interest in
		he or she is about to die, long	g standing activities or ng with family/friends
			duced social interaction
E2.	MOOD PERSIS-	One or more indicators of depressed, sad on not easily altered by attempts to "cheer up	
	TENCE		dicators present,
E4.		(A) Behavioral symptom frequency in last 7	ot easily altered 7 days
	SYMPTOMS	Behavior not exhibited in last 7 days Behavior of this type occurred 1 to 3 day Behavior of this type occurred 4 to 6 day Behavior of this type occurred daily	
		(B) Behavioral symptom alterability in last 0. Behavior not present OR behavior was 6 1. Behavior was not easily altered a. WANDERING (moved with no rational pur	easily altered (A) (I
		oblivious to needs or safety)	,
		b. VERBALLY ABUSIVE BEHAVIORAL SYN were threatened, screamed at, cursed at)	MPTOMS (others
		c. PHYSICALLY ABUSIVE BEHAVIORAL S were hit, shoved, scratched, sexually abuse	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIV SYMPTOMS (made disruptive sounds, no self-abusive acts, sexual behavior or disrot smeared/threw food/feces, hoarding, rumn belongings)	isiness, screaming, ping in public,
		e. RESISTS CARE (resisted taking medication assistance, or eating)	ons/ injections, ADL
G1.	(A) ADL SELF	-PERFORMANCE—(Code for resident's PEI uring last 7 days—Not including setup)	RFORMANCE OVER ALL
	0. INDEPEN during last	DENT—No help or oversight —OR— Help/ov 7 days	
	last7 days 1 or 2 time	SION—Oversight, encouragement or cueing p —OR— Supervision (3 or more times) plus pl s during last 7 days	hysical assistance provided on
	guided ma OR—More	ASSISTANCE—Resident highly involved in acceneuvering of limbs or other nonweight bearing behalp rovided only 1 or 2 times during last 7 ceneurons.	assistance 3 or more times — days
	period, hel —Weight-	/E ASSISTANCE—While resident performed p of following type(s) provided 3 or more times bearing support f performance during part (but not all) of last 7	: :
		PENDENCE—Full staff performance of activi DID NOT OCCUR during entire 7 days	ty during entire 7 days
	(B) ADL SUPF	ORT PROVIDED—(Code for MOST SUPPO . SHIFTS during last 7 days; code regardles	
	performand	ce classification) r physical help from staff	
	 Setup help One persor 	onlý n physical assist 8. ADL a	activity itself did not during entire 7 days
a.	BED MOBILITY	How resident moves to and from lying position and positions body while in bed	
b.	TRANSFER	How resident moves between surfaces—to/fr	rom: bed, chair,
		wheelchair, standing position (EXCLUDE to/f	rom bath/toilet) MDS 2.0 September, 20

G1.					(A)	(B)				
c.	WALK IN ROOM	How resident walks between lo	ocations	in his/her room						
d.	WALK IN CORRIDOR	How resident walks in corridor	on unit							
e.	LOCOMO- TION ON UNIT	How resident moves between adjacent corridor on same floo once in chair								
f.	LOCOMO- TION OFF UNIT	areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair								
g.	DRESSING	How resident puts on, fastens, clothing, including donning/re								
h.	EATING	How resident eats and drinks (nourishment by other means (nutrition)	regardle e.g., tub	ess of skill). Includes intake of e feeding, total parenteral						
i.	TOILET USE	How resident uses the toilet root transfer on/off toilet, cleanses, catheter, adjusts clothes								
j.	PERSONAL HYGIENE	How resident maintains persor brushing teeth, shaving, applyi hands, and perineum (EXCLU	ng make DE bath	eup, washing/drying face, ns and showers)						
G2.	BATHING	How resident takes full-body by transfers in/out of tub/shower (Code for most dependent in (A) BATHING SELF PERFOR	EXCLU self-per MANCE	DE washing of back and hair.) formance.		(A)				
		 Independent—No help pro Supervision—Oversight head 			Г					
		Physical help limited to train		lv						
		Physical help in part of bat		•						
		4. Total dependence								
		8. Activity itself did not occur	during e	entire 7 days						
G3.	TEST FOR	(Code for ability during test in t	he last i	7 days)						
	BALANCE	Maintained position as requ	ired in te	est						
	(see training	 Unsteady, but able to rebala Partial physical support duri 		without physical support						
	manual)	or stands (sits) but does not	follow d							
		Not able to attempt test with Balance while standing	out priy:	sicai neip	Т	\neg				
	a. Balance while standing b. Balance while sitting—position, trunk control									
G4.	FUNCTIONAL	(Code for limitations during las	t 7 days		tions	or				
	LIMITATION IN RANGE OF	placed residents at risk of injur	<i>y</i>)	(B) VOLUNTARY MOVEME	NT					
	MOTION	Ò. No limitation		Ò.´ No loss						
		Limitation on one side Limitation on both sides		 Partial loss Full loss 	(A)	(B)				
		a. Neck								
		b. Arm—Including shoulder or	elbow							
		c. Hand—Including wrist or fine	gers							
		d. Leg—Including hip or knee								
		e. Foot—Including ankle or toe	S							
		f. Other limitation or loss		-1						
G6.	MODES OF TRANSFER	(Check all that apply during la	ast / da	,						
		Bedfast all or most of time	a.	NONE OF ABOVE	f.					
		Bed rails used for bed mobility or transfer	b.							
G7.	TASK SEGMENTA- TION	Some or all of ADL activities w days so that resident could pe 0. No 1. Yes	rform th							
H1.		SELF-CONTROL CATEGOR ident's PERFORMANCE OVE		SHIFTS)						
		IT—Complete control [includes does not leak urine or stool]	use of ii	ndwelling urinary catheter or o	stomy	′				
	BOWEL, les	CONTINENT—BLADDER, inco ss than weekly								
	OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week									
	control pres	TLY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL,	2-3 time	es a week	ome					
		ENT—Had inadequate control E (or almost all) of the time	PLADDE	r, muluple dally episodes;						
a.	BOWEL CONTI- NENCE	Control of bowel movement, w programs, if employed	ith appli	ance or bowel continence						
b.	BLADDER	Control of urinary bladder fund			,					
	CONTI-	programs, if employed	паррііа	nces (e.g., foley) or continence		l l				
H2.	CONTI- NENCE BOWEL	programs, if employed Diarrhea		nces (e.g., toley) or continence						
	CONTI- NENCE	programs, if employed Diarrhea	c.		e.					

Н3.	APPLIANCES AND	Any scheduled toileting plan	a.	Indwelling catheter	d.
	PROGRAMS	Bladder retraining program	b.	Ostomy present	i.
		External (condom) catheter		NONE OF ABOVE	
				current ADL status, cognitive stat	
	od and behavior tive diagnoses)	status, medical treatments, nu	rsing mo	onitoring, or risk of death. (Do not	list
l1.	DISEASES	(If none apply, CHECK the N	IONE O	F ABOVE box)	
		ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis	v.
			a.	Multiple sclerosis	w.
		MUSCULOSKELETAL	u.	Quadriplegia PSYCHIATRIC/MOOD	Z.
		Hip fracture	m.	Depression	00
		NEUROLOGICAL		Manic depressive (bipolar	ee.
		Aphasia Cerebral palsy	r.	disease)	ff.
		Cerebral palsy Cerebrovascular accident	S.	OTHER NONE OF ABOVE	
		(stroke)	t.		rr.
12.	INFECTIONS	(If none apply, CHECK the N	IONE O	,	
		Antibiotic resistant infection (e.g., Methicillin resistant		Septicemia Sexually transmitted diseases	g.
		staph)	a.	Tuberculosis	h. i.
		Clostridium difficile (c. diff.)	b.	Urinary tract infection in last 30	
		Conjunctivitis HIV infection	c. d.	days	j.
		Pneumonia	e.	Viral hepatitis Wound infection	k. I.
		Respiratory infection	f.	NONE OF ABOVE	m.
13.	OTHER			osed in the last 90 days that ha	
	CURRENT	medical treatments, nursing n			otatao,
	AND ICD-9 CODES	a.			1 1
		b.			<u> </u>
J1.	PROBLEM	(Check all problems presen	t in last	7 days unless other time frame is	3
	CONDITIONS	indicated) INDICATORS OF FLUID		OTHER	
		STATUS		Delusions	e.
		Weight gain or loss of 3 or		Edema	g.
		more pounds within a 7 day period	a.	Fever Hallucinations	h.
		Inability to lie flat due to		Internal bleeding	i. j.
		shortness of breath	b.	Recurrent lung aspirations in	,
		Dehydrated; output exceeds input	c.	last 90 days Shortness of breath	k.
		Insufficient fluid; did NOT		Unsteady gait	l. n.
		consume all/almost all liquids provided during last 3 days	d.	Vomiting	o.
				NONE OF ABOVE	p.
J2.	PAIN SYMPTOMS	(Code the highest level of pa	nin prese	• ,	
		a. FREQUENCY with which resident complains or		b. INTENSITY of pain1. Mild pain	
		shows evidence of pain		2. Moderate pain	
		0. No pain (<i>skip to J4</i>) 1. Pain less than daily		3. Times when pain is horrible	
		2. Pain daily		or excrutiating	
J4.	ACCIDENTS	(Check all that apply)		Hip fracture in last 180 days	c.
		Fell in past 30 days Fell in past 31-180 days	a.	Other fracture in last 180 days	d.
J5.	STABILITY		ident's o	NONE OF ABOVE cognitive, ADL, mood or behavior	e.
	OF CONDITIONS	status unstable—(fluctuating,			a.
	CONDITIONS	Resident experiencing an acu chronic problem	te episo	de or a flare-up of a recurrent or	b.
		End-stage disease, 6 or fewer	months	to live	c.
		NONE OF ABOVE			d.
K1.	ORAL PROBLEMS	Chewing problem Swallowing problem			a.
	TROBLEMO	NONE OF ABOVE			b. d.
K2.	HEIGHT	Record (a.) height in inches		weight in pounds. Base weight	on mos
	AND WEIGHT	standard facility practice—e.g.		sure weight consistently in accord after voiding, before meal, with s	
		off, and in nightclothes			
K3.	WEIGHT	a.Weight loss—5 % or more		HT (in.) b. WT (lb.) 0 days; or 10 % or more in last	
	CHANGE	180 days		<u>.</u>	
		0. No 1. Yes b. Weight gain—5 % or more		0 days; or 10 % or more in last	
		180 days		,	
		0. No 1. Yes	3		1

K5.	NUTRI-	(Check all that apply in last 7 days)	
NO.	TIONAL		
	APPROACH-	program	h.
	ES	Feeding tube b. NONE OF ABOVE	i.
	PARENTERAL	(Skip to Section M if neither 5a nor 5b is checked)	
	OR ENTERAL INTAKE	a. Code the proportion of total calories the resident received through	
	INTAKE	parenteral or tube feedings in the last 7 days 0. None 3. 51% to 75%	
		1. 1% to 25% 4. 76% to 100%	
		2. 26% to 50%	
		b. Code the average fluid intake per day by IV or tube in last 7 days	
		0. None 3. 1001 to 1500 cc/day 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day	
		2.501 to 1000 cc/day 5.2001 or more cc/day	
М1.	ULCERS	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply	age
	(Due to any	during last 7 days . Code 9 = 9 or more.) [Requires full body exam.]	Number at Stage
	cause)	a. Stage 1. A persistent area of skin redness (without a break in the	2 10
		skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
M2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)	
		Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue	
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
M4.	OTHER SKIN	Abrasions, bruises	a.
	PROBLEMS OR LESIONS	Burns (second or third degree)	b.
	PRESENT	Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	C.
	(Check all	Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	d.
	that apply	Skin desensitized to pain or pressure	e.
	during last 7 days)	Skin tears or cuts (other than surgery) Surgical wounds	f.
	,	NONE OF ABOVE	g.
M5.	SKIN	Pressure relieving device(s) for chair	h.
IVIJ.	TREAT-	, ,	a.
		Pressure relieving device(s) for bed	h
	MENTS	Turning/repositioning program	b. c.
	MENTS (Check all	3 (7	
	MENTS (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care	c.
	MENTS (Check all that apply	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care	c. d. e. f.
	MENTS (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than	c. d. e. f.
	MENTS (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet	c. d. e. f.
	MENTS (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than	c. d. e. f.
	MENTS (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet)	c. d. e. f. g. h.
M6.	MENTS (Check all that apply during last 7 days)	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses,	c. d. e. f. g. h. i. j.
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems	c. d. e. f. g. h. i. j. a.
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage	c. d. e. f. g. h. i. j.
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot	c. d. e. f. g. h. i. j. a.
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days	c. d. e. f. g. h. i. j. a. b. c. d.
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot	c. d. e. f. g. h. i. j. a. b. c. d. e.
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications)	c. d. e. f. g. h. i. j. a. b. c. d. e. f.
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M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour	c. d. e. f. g. h. i. j. a. b. c. d. e. f.
	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:	c. d. e. f. g. h. i. j. a. b. c. d. e. f.
	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the	c. d. e. f. g. h. i. j. c. d. e. f. g.
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N1.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE ESIGENT IS CO AVERAGE TIME INVOLVED IN ACTIVITIES	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon Evening NONE OF ABOVE (When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None	c. d. e. f. g. h. i. j. a. b. c. d. e. f. g.
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N1. (If ron N2.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is co AVERAGE TIME INVOLVED IN ACTIVITIES NUMBER OF MEDICA-	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon Evening NONE OF ABOVE When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None (Record the number of different medications used in the last 7 days)	c. d. e. f. g. h. i. j. a. b. c. d. e. f. g.
N1. (If ron N2.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE ESIGENT INE INVOLVED IN ACTIVITIES NUMBER OF MEDICATIONS INJECTIONS DAYS	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Worning Afternoon Denote than 1/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None (Record the number of different medications used in the last 7 days; enter "0" if none used) (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if not	c. d. e. f. g. h. i. j. a. b. c. d. e. f. g.
N1. (If ro N2. O1. O3.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is co AVERAGE TIME INVOLVED IN ACTIVITIES NUMBER OF MEDICA- TIONS INJECTIONS DAYS RECEIVED THE	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon When awake and not receiving treatments or ADL care) O. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None (Record the number of different medications used in the last 7 days; enter "0" if none used) (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)	c. d. e. f. g. h. i. j. a. b. c. d. e. f. g.
(lf ro N2. O1.	GENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is concave and a con	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Worning Afternoon Dematose, skip to Section O) (When awake and not receiving treatments or ADL care) O. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used) (Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly) a. Antipsychotic d. Hypnotic	c. d. e. f. g. h. i. j. a. b. c. d. e. f. g.

P1.	SPECIAL TREAT- MENTS.	a. SPECIAL CARE—Check to the last 14 days	reatmen	ts or programs receiv	ed du	ring						
	PROCE-	TREATMENTS		Ventilator or respira	tor							
	DURES, AND PROGRAMS	Chemotherapy	a.	PROGRAMS			I.					
	i itoora amo	Dialysis	b.	Alcohol/drug treatm	nent							
		IV medication	c.	program			m.					
		Intake/output	d.	Alzheimer's/demen	itia spe	ecial						
		Monitoring acute medical		care unit			n.					
		condition	e.	Hospice care Pediatric unit			о. р.					
		Ostomy care	f.	Respite care			q.					
		Oxygen therapy	g.	Training in skills reg	u irod 1	0	ч.					
		Radiation	h.	return to the comm	unity (e.g.,						
		Suctioning	i.	taking medications, work, shopping, trai			r.					
		Tracheostomy care	j.	ADLs)	оро. с							
		Transfusions	k.	NONE OF ABOVE			s.					
b.THERAPIES - Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a in the last 7 calendar days (Enter 0 if none or less than 15 min. da [Note—count only post admission therapies] (A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days (A) (B)												
		· ·			(^)	_	\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ 	_				
		a. Speech - language patholo	ogy and	audiology services		+	+	+				
		b. Occupational therapy				+	+	+				
		c. Physical therapy				+	+	+				
		d. Respiratory therapy	"			+	+	1				
		e. Psychological therapy (by health professional)	any lice	nsed mental								
P3. NURSING REHABILITA- TION RESTOR- ATIVE CARE NURSING Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.) a. Range of motion (passive) b. Range of motion (active) The pressing or grooming and pressing or grooming.												
		c. Splint or brace assistance		g. Dressing or groom	•		-					
		TRAINING AND SKILL		h. Eating or swallow	•							
		PRACTICE IN:		i. Amputation/prost	thesis	care						
		d. Bed mobility		j. Communication								
	DE1/1050	e. Transfer	2047 d	k. Other								
P4.	DEVICES AND RESTRAINTS	Use the following codes for I 0. Not used 1. Used less than daily 2. Used daily	a51 / U	195.								
		Bed rails					Н					
		a. — Full bed rails on all ope	n sides	of bed								
		b. — Other types of side rails	s used (e	e.g., half rail, one side	e)							
		c. Trunk restraint										
		d. Limb restraint										
		e. Chair prevents rising					+					
27.	PHYSICIAN VISITS	In the LAST 14 DAYS (or sinc facility) how many days has th practitioner) examined the res	e physic	cian (or authorized as		t or						
P8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or sind facility) how many days has the practitioner) changed the residence and the residence of the side of the residence of the side of t	e physic dent's or	cian (or authorized as ders? <i>Do not include</i>	sistan							
Q2.	OVERALL	Resident's overall level of self										
CHANGE IN compared to status of 90 days ago (or since last assessment if less CARE NEEDS than 90 days)												
	CARE NEEDS	No change 1. Improved—receives fewer 2. Deteriorated—receives supports, needs less more support										
	CARE NEEDS	supports, ne			ort							
	CARE NEEDS		el of ca	re	ort							
R2.	CARE NEEDS	supports, ne restrictive lev OF PERSON COORDINATIN	el of ca	re ASSESSMENT:	ort							
R2.	SIGNATURE	supports, ne restrictive lev OF PERSON COORDINATIN Assessment Coordinator (sign	el of ca	re ASSESSMENT:	ort							
R2 . a. Si b. D	SIGNATURE	supports, ne restrictive lex OF PERSON COORDINATIN Assessment Coordinator (sign-	on abov	ASSESSMENT: e line)	ort			_				

MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

DISCHARGE TRACKING FORM [do not use for temporary visits home]

SECTION AA. IDENTIFICATION INFORMATION RESIDENT NAME® a. (First) d. (Jr/Sr) b. (Middle Initial) c. (Last) GENDER® 1. Male 2. Female 3. BIRTHDATE® Month Day Year 4. RACE/ 1. American Indian/Alaskan Native 4. Hispanic ETHNICITY® 2. Asian/Pacific Islander 5. White, not of 3. Black, not of Hispanic origin Hispanic origin SOCIAL a. Social Security Number SECURITY® AND MEDICARE NUMBERS ® b. Medicare number (or comparable railroad insurance number) [C in 1st box if non med. no.] FACILITY a. State No. PROVIDER NO.® b. Federal No. MEDICAID NO. ["+" if pending, "N' if not a Medicaid recipient] € [Note—Other codes do not apply to this form] 8. **REASONS** FOR a. Primary reason for assessment ASSESS-MENT Discharged—return not anticipated Discharged—return anticipated 8. Discharged prior to completing initial assessment 9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued partici-pation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf. Signature and Title Sections Date a.

SECTION AB. DEMOGRAPHIC INFORMATION

		[Complete only for stays less than 14 days] (AA88	a=8,
1.	DATE OF ENTRY	Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use admission date	
		Month Day Year	
2.	ADMITTED FROM (AT ENTRY)	Private home/apt. with no home health services Private home/apt. with home health services Board and care/assisted living/group home	
	,	4. Nursing home 5. Acute care hospital	
		Rehabilitation hospital Rehabilitation hospital Rehabilitation hospital	

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

	6.	MEDICAL RECORD NO.														
--	----	--------------------------	--	--	--	--	--	--	--	--	--	--	--	--	--	--

SECTION R. ASSESSMENT/DISCHARGE INFORMATION

3.	DISCHARGE	a. Code for resident disposition upon discharge							
	STATUS	Private home/apartment with no home health services							
		2. Private home/apartment with home health services							
		3. Board and care/assisted living							
		Another nursing facility							
		5. Acute care hospital							
		6. Psychiatric hopital, MR/DD facility							
		7. Rehabilitation hospital							
		8. Deceased							
		9. Other							
		b. Optional State Code							
4.	DISCHARGE	Date of death or discharge							
	DATE								
		Month Day Year							

 $^{^{\}odot}$ = Key items for computerized resident tracking

MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

REENTRY TRACKING FORM

SE	CTION A	Α.	ID	ΈN	ΝT	IFI	CA	TIC	N	IN	FC	DR	M	ΑT	10	Ν						
1.	RESIDENT NAME ®																					
		a.	(Fir	st)			ŀ). (M	iddl	e Init	tial)				С. (Las	t)		(d. (J	r/Sr))
2.	GENDER®	1.1	Mal	е				2.	Fer	nale												
3.	3. BIRTHDATE® Month Day Year																					
4	4. RACE/ 1. American Indian/Alaskan Native 4. Hispanic																					
	ETHNICITY® 2. Asian/Pacific Islander 5. White, not of 3. Black, not of Hispanic origin Hispanic origin																					
5.	SOCIAL	a.	Soc	cial	Sec	urity	Nun	nber									_					
	SECURITY® AND MEDICARE]—				_											
	NUMBERS €	Ι.	Med	dica	ıre r	numb	er (c	or co	mpa	arabl	e ra	ailro	ad i	nsı	ıran	ce n	um	ber)				
	[C in 1st box if non med. no.]																					
6.	FACILITY	a. '	Stat	te N	o.																	
	PROVIDER NO.®]
	b. Federal No.																					
7.																						
	NO. ["+" if pending, "N"																					
	pending, "N" if not a Medicaid																					
	recipient] €																					
8.		[No	ote-	-Ot	ther	cod	es d	o not	app	oly to	th	is fo	orm]									
	FOR ASSESS-	a.	Prin	nary	y rea	asor	for a	asse	ssm	ent												
	MENT		9. F	≀eer	ntry																	
	9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form																					
	rtify that the ac																					
	rmation for this es specified. To																					
app	icable Medicar	e a	and	Med	dica	iy kii aid re	equir	eme:	, mi nts.	lun	idei	ıaıı rsta	nd t	was that	t this	iecte infe	eu i orm	n ao natio	n is	uar	ed a	wiin as a
bas	is for ensuring t	hat	t res	side	nts i	rece	ive a	ppro	pria	ite a	nd	qua	ality	car	e, a	nd a	ıs a	bas	sis f	or p	aym	nent
pati	n federal funds. on in the govern	i tu ime	uπne ent-f	ər uı func	nae Jed	rstar heal	na tn th ca	at pa ire bi	aym roar	ent ams	or s is (con	n red ditio	aera one	ai tui d on	nas the	and	a co cura	ntin ICV 8	uea and '	par truth	τιςι- 1ful-
nes	s of this informa stantial criminal	ation	n, aı ivil,	nd t and	hat d/or	I ma	y be	pers trativ	sona e p	ally s enal	ubj ties	ject fo	to o	or m ıbm	nay s	subj	ect Ise	my info	org	aniz	atio	n to
	ify that I am au Signature and T			d to	Su	bmit	this	info	ma	tion	by	this	fac	ility		its b Sect						Date
	J																					
a.		_			_																	_
h																						

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

4a.	DATE OF REENTRY	Date of reentry Month Day Year
4b.	ADMITTED FROM (AT REENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other
6.	MEDICAL RECORD NO.	

 $^{^{\}scriptsize\textcircled{3}}$ = Key items for computerized resident tracking

SECTION U. MEDICATIONS—CASE MIX DEMO

List all medications that the resident **received** during the last 7 days. Include scheduled medications that are used regularly, but less than weekly.

- 1. Medication Name and Dose Ordered. Record the name of the medication and dose ordered.
- 2. Route of Administration (RA). Code the Route of Administration using the following list:

1=by mouth (PO)5=subcutaneous (SQ)8=inhalation2=sub lingual (SL)6=rectal (R)9=enteral tube3=intramuscular (IM)7=topical10=other

4=intravenous (IV)

3. **Frequency.** Code the number of times per day, week, or month the medication is administered using the following list:

PR=(PRN) as necessary 2D=(BID) two times daily QO=every other day

 $\begin{array}{lll} 1H=(QH) \ every \ hour & (includes \ every \ 12 \ hrs) & 4W=4 \ times \ each \ week \\ 2H=(Q2H) \ every \ two \ hours & 3D=(TID) \ three \ times \ daily & 5W=five \ times \ each \ week \\ 3H=(Q3H) \ every \ three \ hours & 4D=(QID) \ four \ times \ daily & 6W=six \ times \ each \ week \\ \end{array}$

4H=(Q4H) every four hours 5D=five times daily 1M=(Q month) once every month

6H=(Q6H) every six hours 1W=(Q week) once each wk 2M=twice every month

8H=(Q8H) every eight hours 2W=two times every week C=continuous 1D=(QD or HS) once daily 3W=three times every week O=other

- 4. **Amount Administered** (**AA**). Record the number of tablets, capsules, suppositories, or liquid (any route) **per dose** administered to the resident. Code 999 for topicals, eye drops, inhalants and oral medications that need to be dissolved in water..
- 5. **PRN-number of days (PRN-n).** If the frequency code for the medication is "PR", record the number of times during the last 7 days each PRN medication was given. Code STAT medications as PRNs given once.
- 6. **NDC Codes.** Enter the National Drug Code for each medication given. Be sure to enter the correct NDC code for the drug name, strength, and form. The NDC code must match the drug dispensed by the pharmacy.

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6.	ND	C (Coc	les		
										\coprod	
										Ш	
										\prod	
										\prod	

MDS MEDICARE PPS ASSESSMENT FORM (VERSION JULY 2002)

AB5.	RESIDEN- TIAL	(Check all settings resident lived in during 5 years prior to date of entry.)
	HISTORY	a. Prior stay at this nursing home
	5 YEARS PRIOR TO	b. Stay in other nursing home c. Other residential facility—board and care home, assisted living,
	ENTRY	group home
		d. MH/psychiatric setting e. MR/DD setting
		f. NONE OF ABOVE
A1.	RESIDENT	
	NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
A2.	ROOM	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
	NUMBER	
А3.	ASSESS-	a. Last day of MDS observation period
	MENT REFERENCE	
	DATE	Month Day Year
A4a		Date of reentry from most recent temporary discharge to a hospital in
	REENTRY	last 90 days (or since last assessment or admission if less than 90 days)
		Month Day Year
A5.	MARITAL	Never married
A6.	STATUS MEDICAL	2. Married 4. Separated
	RECORD NO.	
A10.	ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical record, check all that apply)
	DIRLOTIVLO	b. Do not resuscitate c. Do not hospitalize
B1.	COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (If Yes, skip to Section G)
B2.	MEMORY	(Recall of what was learned or known)
		a. Short-term memory OK—seems/appears to recall after 5 minutes
		0. Memory OK 1. Memory problem
		b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem
В3.	MEMORY/	(Check all that resident was normally able to recall during
	RECALL ABILITY	a. Current season d. That he/she is in a nursing home
		b. Location of own room e. NONE OF ABOVE are recalled
		c. Staff names/faces
B4.	COGNITIVE SKILLS FOR	(Made decisions regarding tasks of daily life) 0. INDEPENDENT—decisions consistent/reasonable
	DAILY DECISION-	MODIFIED INDEPENDENCE—some difficulty in new situations
	MAKING	only
		MODERATELY IMPAIRED—decisions poor; cues/supervision required
		3. SEVERELY IMPAIRED—never/rarely made decisions
B5.	INDICATORS OF	(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge
	DELIRIUM—	of resident's behavior over this time].
	PERIODIC DISOR-	Behavior not present Behavior present, not of recent onset
	DERED THINKING/	Behavior present, over last 7 days appears different from resident's usual
	AWARENESS	functioning (e.g., new onset or worsening)
		a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
		b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
		EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
		d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
		e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
		f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes protect sometimes not)

C4.	MAKING	(Expressing information conte	nt—however able)	
	SELF UNDER-	0. UNDERSTOOD		
	STOOD		—difficulty finding words or finishing	
		thoughts	OD abilitaria limita da madina	
		concrete requests	OD—ability is limited to making	
		3. RARELY/NEVER UNDERS	STOOD	
C6.	ABILITY TO	(Understanding verbal informat		
	UNDER-	0.UNDERSTANDS	,	
	STAND OTHERS	1.USUALLY UNDERSTANDS-	-may miss some part/intent of	
		message		
		2.SOMETIMES UNDERSTAN	DS—responds adequately to simple,	
		3. RARELY/NEVER UNDERST	TANDS	
D1.	VISION	(Ability to see in adequate light		
		0. ADEQUATE—sees fine deta	il, including regular print in	
		newspapers/books		
		1. IIVIPAIRED—sees large print books	, but not regular print in newspapers/	
		2. MODERATELY IMPAIRED—	limited vision; not able to see	
		newspaper headlines, but ca	* *	
		3. HIGHLY IMPAIRED—object appear to follow objects	identification in question, but eyes	
			vision or sees only light, colors, or	
		shapes; eyes do not appear		
E1.		(Code for indicators observed in las	t 30 days, irrespective of the assumed cause)	
	OF DEPRES-	Indicator not exhibited in last	•	
	SION, ANXIETY,	Indicator of this type exhibite		
	SAD MOOD	2. Indicator of this type exhibite	d daily or almost daily (6, 7 days a week)	
		VERBAL EXPRESSIONS OF DISTRESS	h. Repetitive health complaints—e.g.,	
			persistently seeks medical	
		Resident made negative statements—e.g., "Nothing matters; Would rather be	attention, obsessive concern with body functions	
		matters; Would rather be dead; What's the use;	i. Repetitive anxious	
		Regrets having lived so long; Let me die"	complaints/concerns (non-health related) e.g.,	
		ŭ.	persistently seeks attention/	
		b. Repetitive questions—e.g., "Where do I go; What do I	reassurance regarding schedules, meals, laundry,	
		do?"	clothing, relationship issues	
		 c. Repetitive verbalizations— e.g., calling out for help, 	SLEEP-CYCLE ISSUES	
		("God help me")	j. Unpleasant mood in	
		d. Persistent anger with self	morning	
		or others—e.g., easily annoyed, anger at	k. Insomnia/change in usual sleep pattern	
		placement in nursing home; anger at care	SAD, APATHETIC, ANXIOUS	
		received	APPEARANCE	
		e. Self deprecation—e.g., "/	 Sad, pained, worried facial expressions—e.g., 	
		am nothing; I am of no use to anyone"	furrowed brows	
		f. Expressions of what	m. Crying, tearfulness	
		appear to be unrealistic	n. Repetitive physical	
		fears—e.g., fear of being abandoned, left alone,	movements—e.g., pacing, hand wringing, restlessness,	
		being with others	fidgeting, picking	
		g. Recurrent statements that something terrible is about	LOSS OF INTEREST	
		to happen—e.g., believes	 O. Withdrawal from activities of interest—e.g., no interest 	
		he or she is about to die, have a heart attack	in long standing activities or	
		a mount allaon	being with family/friends p. Reduced social interaction	
E2.	MOOD	One or more indicators of de-	p. Reduced social interaction oressed, sad or anxious mood were	
	PERSIS- TENCE		s to "cheer up", console, or reassure	
		No mood 1. Indicators pre indicators easily altered		
ட		1	, 6.10.00	

Numeric Identifier ____

MDS 2.0 PPS July 2002

Res	ident Identifier_						Nume	ric Identi	ifier	
4.	BEHAVIORAL	(A) Behavioral symptom frequency in last 7 days			G3.	TEST FOR	(Code for ability during test in	he last 7	days)	
	SYMPTOMS	Behavior not exhibited in last 7 days				BALANCE	Maintained position as requ	ired in te	est	
		1. Behavior of this type occurred 1 to 3 days in last 7 days				(see training manual)	 Unsteady, but able to rebala Partial physical support duri 		without physical support	
		2. Behavior of this type occurred 4 to 6 days, but less than daily				,	or stands (sits) but does not 3. Not able to attempt test with			
		Behavior of this type occurred daily					a. Balance while standing	out priys	siodi Noip	
		(B) Behavioral symptom alterability in last 7 days					b. Balance while sitting—positi	on, trunk	control	
		Behavior not present OR behavior was easily altered			G4.		(Code for limitations during las		s that interfered with daily fund	tions or
		Behavior was not easily altered	(A)	(B)		IN RANGE OF	placed residents at risk of inju- (A) RANGE OF MOTION	<i>y</i>)	(B) VOLUNTARY MOVEME	NT
		a. WANDERING (moved with no rational purpose, seemingly				MOTION	No limitation Limitation on one side		Ò. No loss1. Partial loss	
		oblivious to needs or safety)					Limitation on both sides		2. Full loss	(A) (B
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)					a. Neck	_		
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others					b. Arm—Including shoulder or			\vdash
		were hit, shoved, scratched, sexually abused)					c. Hand—Including wrist or find. Leg—Including hip or knee	gers		
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL					e. Foot—Including ankle or too	es.		
		SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public,					f. Other limitation or loss			
		smeared/threw food/feces, hoarding, rummaged through others'			G5.	MODES OF	(Check if applied during last 7 day	s)		
		belongings)				LOCOMO- TION	b. Wheeled self			
		e. RESISTS CARE (resisted taking medications/injections, ADL assistance, or eating)			G6.	MODES OF	(Check all that apply during last 7	davs)		
1.		-PERFORMANCE—(Code for resident's PERFORMANCE OVER A	ALL			TDANCEED	a. Bedfast all or most of time	• • ,		
		uring last 7 days—Not including setup)	l or 2				b. Bed rails used for bed			
		ENT—No help or oversight —OR— Help/oversight provided only 1 or 2 last 7 days			<u></u>		mobility or transfer		· · · · · · · · · · · · · · · · · · ·	
	1. SUPERVI	ISION—Oversight, encouragement or cueing provided 3 or more times during			G7.	TASK SEGMENTA-	Some or all of ADL activities we days so that resident could pe			′
		rs —OR— Supervision (3 or more times) plus physical assistance provided only les during last 7 days			<u></u>	TION	0. No 1. Yes			
		ASSISTANCE—Resident highly involved in activity; received physica	l help		H1.		E SELF-CONTROL CATEGOF nt's PERFORMANCE OVER ALL S F			
	in guided	maneuvering of limbs or other nonweight bearing assistance 3 or mo				,		,	ndwelling urinary catheter or o	oetomy
		-More help provided only 1 or 2 times during last 7 days				CONTINENT—Complete control [includes use of indwelling urinary cathed device that does not leak urine or stool]				Storry
	period, he	VE ASSISTANCE—While resident performed part of activity, over last p of following type(s) provided 3 or more times:	si /-ua	ч		1. USUALLY (CONTINENT—BLADDER, inco	ontinent e	episodes once a week or less;	;
		bearing support ff performance during part (but not all) of last 7 days				BOWEL, les	ss than weekly			
		FPENDENCE—Full staff performance of activity during entire 7 days					NALLY INCONTINENT—BLAD	DER, 2 (or more times a week but not	daily;
	8. ACTIVITY	DID NOT OCCUR during entire 7 days				BOWEL, or				
	(B) ADI SUP	PORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL					TLY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL			some
	` SHIFTS dur	ing last 7 days; code regardless of resident's self-performance	(A)	(B)		·	ENT—Had inadequate control			
	classificati	on) or physical help from staff	RF	ь			(or almost all) of the time		_rt, multiple daily episodes,	
	 Setup help 	o onlý	#	p	a.	BOWEL CONTI-	Control of bowel movement, v	ith applia	ance or bowel continence	
		on physical assist 8. ADL activity itself did not occur during entire 7days	SELF-PERF	SUPPORT		NENCE	programs, if employed			
a.		How resident moves to and from lying position, turns side to side,	0,	0,	b.	BLADDER CONTI-	Control of urinary bladder fund soak through underpants), with	xtion (if di h appliar	ribbles, volume insufficient to nces (e.g., foley) or continence	е
		and positions body while in bed				NENCE	programs, if employed			+
b.		How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)			H2.	BOWEL ELIMINATION	c. Diarrhea			
C.	VAVA L IZ INI					PATTERN	d. Fecal impaction		_	
	ROOM	How resident walks between locations in his/her room			H3.	APPLIANCES AND	a. Any scheduled toileting plarb. Bladder retraining program	' —	 d. Indwelling cathete i. Ostomy present 	er
J.	WALK IN CORRIDOR	How resident walks in corridor on unit				PROGRAMS	c. External (condom) catheter		- " Colomy processic	
∍.		How resident moves between locations in his/her room and			For	Section I · che	eck only those diseases that	have a r	elationshin to current ADL st	atus
		adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair			cog	nitive status, mo	ood and behavior status, medic			
f.	LOCOMO-	How resident moves to and returns from off unit locations (e.g.,			dea	th. (Do not list ir	nactive diagnoses)			
	OFF UNIT	areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on			11.	DISEASES	a. Diabetes melitus		v. Hemiplegia/Hemiparesis	3
		the floor. If in wheelchair, self-sufficiency once in chair					d. Arteriosclerotic heart		w. Multiple sclerosis	
g.	DRESSING	How resident puts on, fastens, and takes off all items of clothing , including donning/removing prosthesis					disease (ASHD)	\vdash	x. Paraplegia	
ր.	EATING	How resident eats and drinks (regardless of skill). Includes intake of					f. Congestive heart failurej. Peripheral vascular		z. Quadriplegia	
		nourishment by other means (e.g., tube feeding, total parenteral nutrition)					disease		ee. Depression	
i.	-	How resident uses the toilet room (or commode, bedpan, urinal);					m. Hip fracture		ff. Manic depressive (bipola disease)	ar
		transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes					r. Aphasia		gg. Schizophrenia	
-	-	How resident maintains personal hygiene, including combing hair,					s. Cerebral palsy		hh. Asthma	
٦.	HYGIENE	brushing teeth, shaving, applying makeup, washing/drying face,					t. Cerebrovascular accident		ii. Emphysema/COPD	
_		hands, and perineum (EXCLUDE baths and showers) How resident takes full-body bath/shower, sponge bath, and			<u> </u>	INICCOTIONS	(stroke)	L		
32.		transfers in/out of tub/shower (EXCLUDE washing of back and			12.	INFECTIONS	(If none apply, CHECK the NONE C a. Antibiotic resitant infection	r ABOVE	box) g. Septicemia	
	-	hair.) Code for most dependent in self-performance. (A) BATHING SELF PERFORMANCE codes appear below		(4)			(e.g. Methicillin resistant		h. Sexually transmitted	
		Independent—No help provided	_	(A)			staph) b. Clastridium difficile (a diff.)		diseasés	<u> </u>
		Supervision—Oversight help only					b. Clostridium difficile (c. diff.)c. Conjunctivitis	$\overline{}$	i. Tuberculosis	
		Physical help limited to transfer only					d. HIV infection	-	j. Urinary tract infection in last 30 days	
		Physical help in part of bathing activity					e. Pneumonia	=	k. Viral hepatitis	
		Total dependence Activity itself did not occur during entire 7 days					f. Respiratory infection		I. Wound infection	
		o. Abuvity itooli did not occur during entire / days			1		i .		m NONE OF ABOVE	1

Resident Identifier ______Numeric Identifier ____

I3.	OTHER			
	OTHER CURRENT			
	DIAGNOSES	a.		
	AND ICD-9	a		
	CODES	b.		
J1.	PROBLEM		ast 7 days unless other time frame is	
	CONDITIONS	indicated)	OTUED	
		INDICATORS OF FLUID	OTHER	
		STATUS	e. Delusions	
		a. Weight gain or loss of 3 or	g. Edema	
		more pounds within a 7-	h. Fever	
		day period	i. Hallucinations	
		b. Inability to lie flat due to	j. Internal bleeding	
		shortness of breath		
		c. Dehydrated; output	k. Recurrent lung aspirations in last 90 days	
		exceeds input	· ·	
		d. Insufficient fluid; did NOT	I. Shortness of breath	
		consume all/almost all	n. Unsteady gait	
		liquids provided during las	t o. Vomiting	
		3 days		
J2.	PAIN	(Code the highest level of pain p	present in the last 7 days	
	SYMPTOMS	a. FREQUENCY with which	b. INTENSITY of pain	
		resident complains or	· ·	
		shows evidence of pain	1. Mild pain	
		0. No pain (<i>skip to J4</i>)	Moderate pain	
		Pain less than daily	3. Times when pain is horril	ole
		•	or excruciating	
		2. Pain daily	a I lin fronture in last 100 days	
J4.	ACCIDENTS	(Check all that apply)	c. Hip fracture in last 180 days	
		a. Fell in past 30 days	d. Other fracture in last 180	
		b. Fell in past 31-180 days	days	
			e. NONE OF ABOVE	
J5.	STABILITY		resident's cognitive, ADL, mood or	
	OF CONDITIONS	benavior patterns unstable-	—(fluctuating, precarious, or deteriorating)	
	CONDITIONS		acute episode or a flare-up of a recurrent	
		or chronic problem		
		c. End-stage disease, 6 or fev	ver months to live	
		d. NONE OF ABOVE		
K1.	ORAL	a. Chewing problem		
	PROBLEMS	b. Swallowing problem		
K2.	HEIGHT		d (b.) weight in pounds. Base weight on mos	st
	AND	recent measure in last 30 days	r; méasure weight consistently in accord v	vith
	WEIGHT		g., in a.m. after voiding, before meal, with s	shoes
	l	off, and in nightclothes		
		off, and in nightclothes	a. HT (in.) b. WT (lb.)	
K3.	WEIGHT	a. Weight loss—5 % or more	a. HT (in.) b. WT (lb.) e in last 30 days; or 10 % or more in last	
K3.	WEIGHT CHANGE		. , ,	
K3.		a. Weight loss—5 % or more	e in last 30 days; or 10 % or more in last	
K3.		a. Weight loss—5 % or more 180 days 0. No 1. Ye	e in last 30 days; or 10 % or more in last	
K3.		a. Weight loss—5 % or more 180 days 0. No 1. Ye	e in last 30 days; or 10 % or more in last	
К3.		a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last	
	CHANGE	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last	
K3.	NUTRI- TIONAL	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or mon 180 days 0. No 1. Ye (Check all that apply in last 7 december 180 days)	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s [a/s]	
	NUTRI- TIONAL APPROACH-	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last e in last 30 days; or 10 % or more in last s ays) h. On a planned weight	
	NUTRI- TIONAL	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or mon 180 days 0. No 1. Ye (Check all that apply in last 7 december 180 days)	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s [a/s]	
K5.	NUTRI- TIONAL APPROACH- ES	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 days) a. Parenteral/IV b. Feeding tube	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s s ays) h. On a planned weight change program	
K5.	NUTRI- TIONAL APPROACH- ES	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 d a. Parenteral/IV b. Feeding tube	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s s ays) h. On a planned weight change program or 5b is checked	
K5.	NUTRI- TIONAL APPROACH- ES	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 d a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a no a. Code the proportion of total	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s fays) h. On a planned weight change program or 5b is checked) al calories the resident received through	
K5.	NUTRI- TIONAL APPROACH- ES PARENTERAL OR ENTERAL	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 d a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a not a. Code the proportion of total parenteral or tube feedings	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s fays) h. On a planned weight change program or 5b is checked) al calories the resident received through in the last 7 days	
K5.	NUTRI- TIONAL APPROACH- ES PARENTERAL OR ENTERAL	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 d a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a not a. Code the proportion of tota parenteral or tube feedings 0. None	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s fays) h. On a planned weight change program al calories the resident received through s in the last 7 days 3.51% to 75%	
K5.	NUTRI- TIONAL APPROACH- ES PARENTERAL OR ENTERAL	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 d a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a not a. Code the proportion of total parenteral or tube feedings	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s fays) h. On a planned weight change program or 5b is checked) al calories the resident received through in the last 7 days	
K5.	NUTRI- TIONAL APPROACH- ES PARENTERAL OR ENTERAL	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 d a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a nd a. Code the proportion of total parenteral or tube feedings 0. None 1. 1% to 25% 2. 26% to 50%	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s lays) h. On a planned weight change program al calories the resident received through in the last 7 days 3.51% to 75% 4.76% to 100%	
K5.	NUTRI- TIONAL APPROACH- ES PARENTERAL OR ENTERAL	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 d a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a not a. Code the proportion of total parenteral or tube feedings 0. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid into	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s ays) h. On a planned weight change program al calories the resident received through in the last 7 days 3. 51% to 75% 4. 76% to 100% ake per day by IV or tube in last 7 days	
K5.	NUTRI- TIONAL APPROACH- ES PARENTERAL OR ENTERAL	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 d a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a nd a. Code the proportion of total parenteral or tube feedings 0. None 1. 1% to 25% 2. 26% to 50%	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s lays) h. On a planned weight change program al calories the resident received through in the last 7 days 3.51% to 75% 4.76% to 100%	
K5.	NUTRI- TIONAL APPROACH- ES PARENTERAL OR ENTERAL	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 da. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a not a. Code the proportion of tota parenteral or tube feedings 0. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid into 0. None	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s ays) h. On a planned weight change program h. On a planned weight change program at calories the resident received through in the last 7 days 3. 51% to 75% 4. 76% to 100% ake per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day	
K5.	NUTRI- TIONAL APPROACH- ES PARENTERAL OR ENTERAL	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 d a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a no a. Code the proportion of total parenteral or tube feedings 0. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid into 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day (Record the number of ulcers	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s lays) h. On a planned weight change program h. On a planned weight change program al calories the resident received through in the last 7 days 3. 51% to 75% 4. 76% to 100% lake per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day at each ulcer stage—regardless of	ge
K5.	NUTRITIONAL APPROACHES PARENTERAL OR ENTERAL INTAKE	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 da. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a no a. Code the proportion of tota parenteral or tube feedings 0. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid into 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day (Record the number of ulcers cause. If none present at a sta	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s ays) h. On a planned weight change program h. On a planned weight change program at calories the resident received through in the last 7 days 3. 51% to 75% 4. 76% to 100% ake per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day at each ulcer stage—regardless of age, record "0" (zero). Code all that apply	mber Stage
K5.	NUTRITIONAL APPROACHES PARENTERAL INTAKE ULCERS (Due to any	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 da. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a no a. Code the proportion of tota parenteral or tube feedings 0. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid into 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day (Record the number of ulcers cause. If none present at a sta	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s lays) h. On a planned weight change program h. On a planned weight change program al calories the resident received through in the last 7 days 3. 51% to 75% 4. 76% to 100% lake per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day at each ulcer stage—regardless of	Number at Stage
K5.	NUTRITIONAL APPROACHES PARENTERAL OR ENTERAL INTAKE	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 days) a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a not parenteral or tube feedings 0. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid into 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day (Record the number of ulcers cause. If none present at a staduring last 7 days. Code 9 = 9.	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s lays) h. On a planned weight change program h. On a planned weight change program al calories the resident received through in the last 7 days 3. 51% to 75% 4. 76% to 100% lake per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day set each ulcer stage—regardless of lage, record "0" (zero). Code all that apply or more.) [Requires full body exam.] lof skin redness (without a break in the	Number at Stage
K5.	NUTRITIONAL APPROACHES PARENTERAL INTAKE ULCERS (Due to any	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 days) a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a not parenteral or tube feedings 0. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid into 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day (Record the number of ulcers cause. If none present at a staduring last 7 days. Code 9 = 9.	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s h. On a planned weight change program h. On a planned weight change program al calories the resident received through in the last 7 days 3. 51% to 75% 4. 76% to 100% ake per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day at each ulcer stage—regardless of age, record "0" (zero). Code all that apply or more.) [Requires full body exam.]	Number at Stage
K5.	NUTRITIONAL APPROACHES PARENTERAL INTAKE ULCERS (Due to any	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 d a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a nd a. Code the proportion of total parenteral or tube feedings 0. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid into 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day (Record the number of ulcers cause. If none present at a staduring last 7 days. Code 9 = 9 a. Stage 1. A persistent area skin) that does not	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s h. On a planned weight change program h. On a planned weight change program al calories the resident received through in the last 7 days 3. 51% to 75% 4. 76% to 100% ake per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day at each ulcer stage—regardless of age, record "0" (zero). Code all that apply or more.) [Requires full body exam.] to f skin redness (without a break in the ot disappear when pressure is relieved.	Number at Stage
K5.	NUTRITIONAL APPROACHES PARENTERAL INTAKE ULCERS (Due to any	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 days) a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a not 2 parenteral or tube feedings 0. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid into 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day (Record the number of ulcers cause. If none present at a staduring last 7 days. Code 9 = 9 a. Stage 1. A persistent area skin) that does not b. Stage 2. A partial thickness	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s lays) h. On a planned weight change program h. On a planned weight change program al calories the resident received through in the last 7 days 3. 51% to 75% 4. 76% to 100% lake per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day set each ulcer stage—regardless of lage, record "0" (zero). Code all that apply or more.) [Requires full body exam.] lof skin redness (without a break in the	Number at Stage
K5.	NUTRITIONAL APPROACHES PARENTERAL INTAKE ULCERS (Due to any	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 days) a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a not a. Code the proportion of tota parenteral or tube feedings 0. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid into 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day (Record the number of ulcers cause. If none present at a staduring last 7 days. Code 9 = 9 a. Stage 1. A persistent area skin) that does not b. Stage 2. A partial thicknes clinically as an at	e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s e in last 30 days; or 10 % or more in last s lays) h. On a planned weight change program h. On a planned weight change program al calories the resident received through s in the last 7 days 3. 51% to 75% 4. 76% to 100% lake per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day s at each ulcer stage—regardless of lage, record "0" (zero). Code all that apply or more.) [Requires full body exam.] s of skin redness (without a break in the ot disappear when pressure is relieved. sis loss of skin layers that presents orasion, blister, or shallow crater.	Number at Stage
K5.	NUTRITIONAL APPROACHES PARENTERAL INTAKE ULCERS (Due to any	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 d a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a nd a. Code the proportion of tota parenteral or tube feedings 0. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid int 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day (Record the number of ulcers cause. If none present at a stiduring last 7 days. Code 9 = 9 a. Stage 1. A persistent area skin) that does no b. Stage 2. A partial thickness o tissues - presents or t	e in last 30 days; or 10 % or more in last se in last 30 days; or 10 % or more in last se in last 30 days; or 10 % or more in last h. On a planned weight change program h. On a planned weight change program al calories the resident received through in the last 7 days 3. 51% to 75% 4. 76% to 100% ake per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day at each ulcer stage—regardless of age, record "0" (zero). Code all that apply or more.) [Requires full body exam.] of skin redness (without a break in the obt disappear when pressure is relieved. It is lost, exposing the subcutaneous is as a deep crater with or without	Number at Stage
K5.	NUTRITIONAL APPROACHES PARENTERAL INTAKE ULCERS (Due to any	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 d a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a nd a. Code the proportion of tota parenteral or tube feedings 0. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid interest of the section of the company of the section of the company of th	e in last 30 days; or 10 % or more in last se in last 30 days; or 10 % or more in last se in last 30 days; or 10 % or more in last se in last 30 days; or 10 % or more in last se in last 30 days; or 10 % or more in last se in last 30 days; or 10 % or more in last se in last 30 days; or 10 % or more in last se in last 7 days al calories the resident received through so in the last 7 days 3. 51% to 75% 4. 76% to 100% sake per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day se at each ulcer stage—regardless of age, record "(zero). Code all that apply or more.) [Requires full body exam.] so f skin redness (without a break in the ot disappear when pressure is relieved. se loss of skin layers that presents orasion, blister, or shallow crater. If skin is lost, exposing the subcutaneous as a deep crater with or without accent tissue.	Number at Stage
K5.	NUTRITIONAL APPROACHES PARENTERAL INTAKE ULCERS (Due to any	a. Weight loss—5 % or more 180 days 0. No 1. Ye b. Weight gain—5 % or more 180 days 0. No 1. Ye (Check all that apply in last 7 d a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a nd a. Code the proportion of tota parenteral or tube feedings 0. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid interest of the section of the company of the section of the company of th	e in last 30 days; or 10 % or more in last se in last 30 days; or 10 % or more in last se in last 30 days; or 10 % or more in last se in last 30 days; or 10 % or more in last se in last 30 days; or 10 % or more in last se in last 30 days; or 10 % or more in last se in last 30 days; or 10 % or more in last se last 30 days; or 10 % or more in last se in last 7 days 3. 51% to 75% 4. 76% to 100% sake per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day se at each ulcer stage—regardless of lage, record "0" (zero). Code all that apply or more.) [Requires full body exam.] so of skin redness (without a break in the ot disappear when pressure is relieved. It is so so so skin layers that presents or shallow crater. If skin is lost, exposing the subcutaneous is as a deep crater with or without accent tissue. If skin and subcutaneous tissue is lost,	Number at Stage

M2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days usin scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)							
		a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue []							
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities							
М3.	HISTORY OF	Resident had an ulcer that wa	ıs resolv	ved or cured in LAST 90 DAYS					
	RESOLVED ULCERS	0. No 1. Yes		od or odrod in Erior oo Britis					
M4.	OTHER SKIN PROBLEMS	a. Abrasions, bruises							
	OR LESIONS	b. Burns (second or third deg	,						
	PRESENT	 c. Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) d. Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes 							
	(Check all that	d. Rashes—e.g., intertrigo, ed zoster	czema,	drug rash, heat rash, herpes					
	apply during last 7 days)	e. Skin desensitized to pain o	r nressi	Ire					
	iast / days)	-							
		g. Surgical wounds	kin tears or cuts (other than surgery) Surgical wounds						
		h. NONE OF ABOVE							
M5.	SKIN	a. Pressure relieving device(s	s) for ch	air					
	TREAT- MENTS	b. Pressure relieving device(s	s) for be	ed					
		c. Turning/repositioning prog	ram						
	(<i>Check all that</i> apply during	d. Nutrition or hydration interv	ention/	to manage skin problems					
	last 7 days)	e. Ulcer care							
		f. Surgical wound care							
		g. Application of dressings (w than to feet	ith or w	ithout topical medications) other					
		h. Application of ointments/m	edicatio	ons (other than to feet)					
		i. Other preventative or prote	ctive sk	in care (other than to feet)					
		j. NONE OF ABOVE							
M6.	FOOT			oblems—e.g., corns, callouses,					
	PROBLEMS AND CARE	b. Infection of the foot—e.g.,		g toes, pain, structural problems					
	(Check all that	c. Open lesions on the foot	Celiulius	, purulent uralnage					
	apply during	d. Nails/calluses trimmed dur	ing las t	90 davs					
	last 7 days)		•	e foot care (e.g., used special					
		shoes, inserts, pads, toe se	eparato	rs)					
		··	oplication of dressings (with or without topical medications)						
N1.	TIME	g. NONE OF ABOVE (Check appropriate time periods)	over lace	17 days					
NI.	AWAKE	Resident awake all or most of	f time (i.	.e., naps no more than one hour					
		per time period) in the: a. Morning	7 . =	vening					
		b. Afternoon	_	IONE OF ABOVE					
(If ı	esident is co	matose, skip to Section							
N2.	AVERAGE	(When awake and not recei	ving tr	eatments or ADL care)					
	TIME INVOLVED IN ACTIVITIES	0. Most—more than 2/3 of tim 1. Some—from 1/3 to 2/3 of ti	more than 2/3 of time 2. Little—less than 1/3 of time						
01.	NUMBER OF MEDICA-	BER OF (Record the number of different medications used in the last 7 days; ento DICA- "0" if none used)		ions used in the last 7 days; enter					
O3.	TIONS	(Record the number of DAYS init	ections	of any type received during the	\vdash				
		last 7 days; enter "0" if none us	sed)						
O4.	DAYS RECEIVED	(<i>Record the number of DAYS</i> du Note—enter "1" for long-actir							
	THE FOLLOWING	a. Antipsychotic		d. Hypnotic					
	MEDICATION	b. Antianxiety		e. Diuretic					
		c. Antidepressant							
P1.	SPECIAL TREAT-	a. SPECIAL CARE—Check during the last 14 days	k treatr	nents or programs received					
	MENTS, PROCE-								
	DURES, AND	TREATMENTS		PROGRAMS					
	PROGRAMS	a. Chemotherapy		m. Alcohol/drug treatment program					
		b. Dialysis		, ,					
		c. IV medication		 n. Alzheimer's/dementia special care unit 					
		d. Intake/output		o. Hospice care					
		e. Monitoring acute medical condition		p. Pediatric unit					
		f. Ostomy care		q. Respite care					
		g. Oxygen therapy		r. Training in skills required to					
		h. Radiation		return to the community (e.g., taking medications,					
		i. Suctioning		house work, shopping, transportation, ADLs)					
		j. Tracheostomy care		, ,					
		k. Transfusions		s. NONE OF THE ABOVE					
		I Ventilator or respirator							

Resident Identifier							Numeric Identifier				
P1.	SPECIAL TREAT- MENTS, PROCE-	b. THERAPIES - Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the calendar days (Enter 0 if none or less than 15 min. daily) [Note — count only post admission therapies]		ay) in the last 7	P8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none)				
	PROGRAMS	(A) = # of days administered for 15 m (B) = total # of minutes provided in Is	ninutes or more	DAYS	MIN	Q1.	DISCHARGE	a. Resident expresses/indicates preference to return to the community			
	INCONAMO		-	(A)	(B)		POTENTIAL	0. No 1. Yes			
		a. Speech - language pathology and	audiology services					c. Stay projected to be of a short duration—discharge projected			
		b. Occupational therapy						within 90 days (do not include expected discharge due to death) 0. No 2. Within 31-90 days			
		c. Physical therapy						1. Within 30 days 3. Discharge status uncertain			
		d. Respiratory therapy				Q2	OVERALL	Resident's overall level of self sufficiency has changed significantly as			
		Psychological therapy (by any licer professional)	nsed mental health				CHANGE IN CARE NEEDS	compared to status of 90 days ago (or since last assessment if less than 90 days)			
P3.	NURSING REHABILITA-	Record the NUMBER OF DAYS earestorative techniques or practices	was provided to the	he reside	nts for			No change 1. Improved—receives 2. Deteriorated—receives fewer supports, needs less restrictive level of			
	TION/ RESTOR-	more than or equal to 15 minutes per day in the last 7 days (ENTER 0 if none or less than 15 min. daily.)			;			care			
	ATIVE CARE	a. Range of motion (passive)	f. Walking			R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:					
		b. Range of motion (active)	· ·								
		c. Splint or brace assistance	g. Dressing	or groomin	ng	a. 9	Signature of RN A	Assessment Coordinator (sign on above line)			
		·	h. Eating or	swallowing	1	b. [Date RN Assessr	ment Coordinator			
		TRAINING AND SKILL PRACTICE IN:	i. Amputation		sis care	signed as complete Month Day Year					
		d. Bed mobility	j. Communi	cation		T1.	SPECIAL	Skip unless this is a Medicare 5 day or Medicare readmission/return			
		e. Transfer	k. Other				TREATMENTS	assessment			
P4.	DEVICES	Use the following codes for last 7 days:				AND PROCE-	b. ORDERED THERAPIES—Has physician ordered any of the				
AND RESTRAINTS		0. Not used					DURES	following therapies to begin in FİRŚT 14 days of stay—physical therapy, occupational therapy, or speech pathology service? 0. No 1.Yes			
		1. Used less than daily									
		2. Used daily						c. Through day15, provide an estimate of the number of days when			
		Bed rails						at least 1 therapy service can be expected to have been delivered.			
		a. —Full bed rails on all open side	s of bed					d. Through day15, provide an estimate of the number of			
		b. —Other types of side rails used	l (e.g., half rail, one	side)				therapy minutes (across the therapies) that can be			
		c. Trunk restraint						expected to be delivered.			

CASE MIX GROUP

Medicare

State

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T3.

d. Limb restraint

PHYSICIAN VISITS

e. Chair prevents rising
 In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 0 if none)